

No. 22-11707

**UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT**

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PAUL A. EKNES-TUCKER, et al.,
Plaintiffs-Appellees,

&

UNITED STATES OF AMERICA
Intervenor-Plaintiff-Appellee,

v.

GOVERNOR OF THE STATE OF ALABAMA, et al.,
Defendants-Appellants.

◆

On Appeal from the United States District Court
for the Middle District of Alabama
Case No. 2:22-cv-184-LCB

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APPENDIX D

EVIDENCE FOR CLINICAL OUTCOMES OF THERAPEUTIC APPROACHES

One of the real supports for any new therapy is an outcome analysis. Because of the controversial nature of sex reassignment surgery, this type of analysis has been very important. Almost all of the outcome studies in this area have been retrospective.

One of the first studies to examine the post-treatment psychosocial outcomes of transsexual patients was done in 1979 at Johns Hopkins University School of Medicine and Hospital (USA) (J. K. Meyer & Reter, 1979). This study focused on patients' occupational, educational, marital, and domiciliary stability. The results revealed several significant changes with treatment. These changes were not seen as positive; rather, they showed that many individuals who had entered the treatment program were no better off or were worse off in many measures after participation in the program. These findings resulted in closure of the treatment program at that hospital/medical school (Abramowitz, 1986).

Subsequently, a significant number of health professionals called for a standard for eligibility for sex reassignment surgery. This led to the formulation of the original *Standards of Care* of the Harry Benjamin International Gender Dysphoria Association (now WPATH) in 1979.

In 1981, Pauly published results from a large retrospective study of people who had undergone sex reassignment surgery. Participants in that study had much better outcomes: Among 83 FtM patients, 80.7% had a satisfactory outcome (i.e., patient self report of "improved social and emotional adjustment"), 6.0% unsatisfactory. Among 283 MtF patients, 71.4% had a satisfactory outcome, 8.1% unsatisfactory. This study included patients who were treated before the publication and use of the *Standards of Care*.

Since the *Standards of Care* have been in place, there has been a steady increase in patient satisfaction and decrease in dissatisfaction with the outcome of sex reassignment surgery. Studies conducted after 1996 focused on patients who were treated according to the *Standards of Care*. The findings of Rehman and colleagues (1999) and Krege and colleagues (2001) are typical of this body of work; none of the patients in these studies regretted having had surgery, and most reported being satisfied with the cosmetic and functional results of the surgery. Even patients who develop severe surgical complications seldom regret having undergone surgery. Quality of surgical results is one of the best predictors of the overall outcome of sex reassignment (Lawrence, 2003). The vast majority of follow-up studies have shown an undeniable beneficial effect of sex reassignment surgery on postoperative outcomes such as subjective well being, cosmesis, and sexual function (De Cuypere et al., 2005; Garaffa, Christopher, & Ralph, 2010; Klein & Gorzalka, 2009), although the specific magnitude of benefit is uncertain from

the currently available evidence. One study (Emory, Cole, Avery, Meyer, & Meyer, 2003) even showed improvement in patient income.

One troubling report (Newfield et al., 2006) documented lower scores on quality of life (measured with the SF-36) for FtM patients than for the general population. A weakness of that study is that it recruited its 384 participants by a general email rather than a systematic approach, and the degree and type of treatment were not recorded. Study participants who were taking testosterone had typically been doing so for less than 5 years. Reported quality of life was higher for patients who had undergone breast/chest surgery than for those who had not ($p < .001$). (A similar analysis was not done for genital surgery.) In other work, Kuhn and colleagues (2009) used the King's Health Questionnaire to assess the quality of life of 55 transsexual patients at 15 years after surgery. Scores were compared to those of 20 healthy female control patients who had undergone abdominal/pelvic surgery in the past. Quality of life scores for transsexual patients were the same or better than those of control patients for some subscales (emotions, sleep, incontinence, symptom severity, and role limitation), but worse in other domains (general health, physical limitation, and personal limitation).

Two long-term observational studies, both retrospective, compared the mortality and psychiatric morbidity of transsexual adults to those of general population samples (Asscheman et al., 2011; Dhejne et al., 2011). An analysis of data from the Swedish National Board of Health and Welfare information registry found that individuals who had received sex reassignment surgery (191 MtF and 133 FtM) had significantly higher rates of mortality, suicide, suicidal behavior, and psychiatric morbidity than those for a nontranssexual control group matched on age, immigrant status, prior psychiatric morbidity, and birth sex (Dhejne et al., 2011). Similarly, a study in the Netherlands reported a higher total mortality rate, including incidence of suicide, in both pre- and post-surgery transsexual patients (966 MtF and 365 FtM) than in the general population of that country (Asscheman et al., 2011). Neither of these studies questioned the efficacy of sex reassignment; indeed, both lacked an adequate comparison group of transsexuals who either did not receive treatment or who received treatment other than genital surgery. Moreover, transsexual people in these studies were treated as far back as the 1970s. However, these findings do emphasize the need to have good long-term psychological and psychiatric care available for this population. More studies are needed that focus on the outcomes of current assessment and treatment approaches for gender dysphoria.

It is difficult to determine the effectiveness of hormones alone in the relief of gender dysphoria. Most studies evaluating the effectiveness of masculinizing/feminizing hormone therapy on gender dysphoria have been conducted with patients who have also undergone sex reassignment surgery. Favorable effects of therapies that included both hormones and surgery were reported in a comprehensive review of over 3000 patients in 79 studies (mostly observational) conducted between 1961 and 1991 (Eldh, Berg, & Gustafsson, 1997; Gijs & Brewaeys, 2007; Murad et al., 2010; Pfäfflin & Junge, 1998). Patients operated on after 1986 did better than those before 1986; this reflects significant improvement in surgical complications (Eldh et al., 1997). Most patients have reported improved psychosocial outcomes, ranging between 87% for MtF patients and 97% for FtM patients (Green & Fleming, 1990).

Similar improvements were found in a Swedish study in which “almost all patients were satisfied with sex reassignment at 5 years, and 86% were assessed by clinicians at follow-up as stable or improved in global functioning” (Johansson, Sundbom, Höjerback, & Bodlund, 2010). Weaknesses of these earlier studies are their retrospective design and use of different criteria to evaluate outcomes.

A prospective study conducted in the Netherlands evaluated 325 consecutive adult and adolescent subjects seeking sex reassignment (Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). Patients who underwent sex reassignment therapy (both hormonal and surgical intervention) showed improvements in their mean gender dysphoria scores, measured by the Utrecht Gender Dysphoria Scale. Scores for body dissatisfaction and psychological function also improved in most categories. Fewer than 2% of patients expressed regret after therapy. This is the largest prospective study to affirm the results from retrospective studies that a combination of hormone therapy and surgery improves gender dysphoria and other areas of psychosocial functioning. There is a need for further research on the effects of hormone therapy without surgery, and without the goal of maximum physical feminization or masculinization.

Overall, studies have been reporting a steady improvement in outcomes as the field becomes more advanced. Outcome research has mainly focused on the outcome of sex reassignment surgery. In current practice there is a range of identity, role, and physical adaptations that could use additional follow-up or outcome research (Institute of Medicine, 2011).

APPENDIX E

DEVELOPMENT PROCESS FOR THE STANDARDS OF CARE, VERSION 7

The process of developing *Standards of Care, Version 7* began when an initial SOC “work group” was established in 2006. Members were invited to examine specific sections of SOC, *Version 6*. For each section, they were asked to review the relevant literature, identify where research was lacking and needed, and recommend potential revisions to the SOC as warranted by new evidence. Invited papers were submitted by the following authors: Aaron Devor, Walter Bockting, George Brown, Michael Brownstein, Peggy Cohen-Kettenis, Griet DeCuypere, Petra DeSutter, Jamie Feldman, Lin Fraser, Arlene Istar Lev, Stephen Levine, Walter Meyer, Heino Meyer-Bahlburg, Stan Monstrey, Loren Schechter, Mick van Trotsenburg, Sam Winter, and Ken Zucker. Some of these authors chose to add co-authors to assist them in their task.

Initial drafts of these papers were due June 1, 2007. Most were completed by September 2007, with the rest completed by the end of 2007. These manuscripts were then submitted to the *International*

Journal of Transgenderism (IJT). Each underwent the regular *IJT* peer review process. The final papers were published in Volume 11 (1–4) in 2009, making them available for discussion and debate.

After these articles were published, an SOC Revision Committee was established by the WPATH Board of Directors in 2010. The Revision Committee was first charged with debating and discussing the *IJT* background papers through a Google website. A subgroup of the Revision Committee was appointed by the Board of Directors to serve as the Writing Group. This group was charged with preparing the first draft of SOC, *Version 7* and continuing to work on revisions for consideration by the broader Revision Committee. The Board also appointed an International Advisory Group of transsexual, transgender, and gender-nonconforming individuals to give input on the revision.

A technical writer was hired to (1) review all of the recommendations for revision—both the original recommendations as outlined in the *IJT* articles and additional recommendations that emanated from the online discussion—and (2) create a survey to solicit further input on these potential revisions. From the survey results, the Writing Group was able to discern where these experts stood in terms of areas of agreement and areas in need of more discussion and debate. The technical writer then (3) created a very rough first draft of SOC, *Version 7* for the Writing Group to consider and build on.

The Writing Group met on March 4 and 5, 2011 in a face-to-face expert consultation meeting. They reviewed all recommended changes and debated and came to consensus on various controversial areas. Decisions were made based on the best available science and expert consensus. These decisions were incorporated into the draft, and additional sections were written by the Writing Group with the assistance of the technical writer.

The draft that emerged from the consultation meeting was then circulated among the Writing Group and finalized with the help of the technical writer. Once this initial draft was finalized, it was circulated among the broader SOC Revision Committee and the International Advisory Group. Discussion was opened up on the Google website and a conference call was held to resolve issues. Feedback from these groups was considered by the Writing Group, who then made further revisions. Two additional drafts were created and posted on the Google website for consideration by the broader SOC Revision Committee and the International Advisory Group. Upon completion of these three iterations of review and revision, the final document was presented to the WPATH Board of Directors for approval. The Board of Directors approved this version on September 14, 2011.

Funding

The *Standards of Care* revision process was made possible through a generous grant from the Tawani Foundation and a gift from an anonymous donor. These funds supported the following:

1. Costs of a professional technical writer;
2. Process of soliciting international input on proposed changes from gender identity professionals and the transgender community;
3. Working meeting of the Writing Group;
4. Process of gathering additional feedback and arriving at final expert consensus from the professional and transgender communities, the *Standards of Care, Version 7*, Revision Committee, and WPATH Board of Directors;
5. Costs of printing and distributing *Standards of Care, Version 7*, and posting a free downloadable copy on the WPATH website;
6. Plenary session to launch the *Standards of Care, Version 7*, at the 2011 WPATH Biennial Symposium in Atlanta, Georgia, USA.

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[†] All members of the *Standards of Care, Version 7* Revision Committee donated their time to work on this revision.

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DOC. 69-19

Endocrine Treatment of Gender-Dysphoric/ Gender-Incongruent Persons: An Endocrine Society* Clinical Practice Guideline

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***Cosponsoring Associations:** American Association of Clinical Endocrinologists, American Society of Andrology, European Society for Pediatric Endocrinology, European Society of Endocrinology, Pediatric Endocrine Society, and World Professional Association for Transgender Health.

Objective: To update the "Endocrine Treatment of Transsexual Persons: An Endocrine Society Clinical Practice Guideline," published by the Endocrine Society in 2009.

Participants: The participants include an Endocrine Society-appointed task force of nine experts, a methodologist, and a medical writer.

Evidence: This evidence-based guideline was developed using the Grading of Recommendations, Assessment, Development, and Evaluation approach to describe the strength of recommendations and the quality of evidence. The task force commissioned two systematic reviews and used the best available evidence from other published systematic reviews and individual studies.

Consensus Process: Group meetings, conference calls, and e-mail communications enabled consensus. Endocrine Society committees, members and cosponsoring organizations reviewed and commented on preliminary drafts of the guidelines.

Conclusion: Gender affirmation is multidisciplinary treatment in which endocrinologists play an important role. Gender-dysphoric/gender-incongruent persons seek and/or are referred to endocrinologists to develop the physical characteristics of the affirmed gender. They require a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person's genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person's affirmed gender. Hormone treatment is not recommended for prepubertal gender-dysphoric/gender-incongruent persons. Those clinicians who recommend gender-affirming endocrine treatments—appropriately trained diagnosing clinicians (required), a mental health provider for adolescents (required) and mental health

professional for adults (recommended)—should be knowledgeable about the diagnostic criteria and criteria for gender-affirming treatment, have sufficient training and experience in assessing psychopathology, and be willing to participate in the ongoing care throughout the endocrine transition. We recommend treating gender-dysphoric/gender-incongruent adolescents who have entered puberty at Tanner Stage G2/B2 by suppression with gonadotropin-releasing hormone agonists. Clinicians may add gender-affirming hormones after a multidisciplinary team has confirmed the persistence of gender dysphoria/gender incongruence and sufficient mental capacity to give informed consent to this partially irreversible treatment. Most adolescents have this capacity by age 16 years old. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to age 16 years, although there is minimal published experience treating prior to 13.5 to 14 years of age. For the care of peripubertal youths and older adolescents, we recommend that an expert multidisciplinary team comprised of medical professionals and mental health professionals manage this treatment. The treating physician must confirm the criteria for treatment used by the referring mental health practitioner and collaborate with them in decisions about gender-affirming surgery in older adolescents. For adult gender-dysphoric/gender-incongruent persons, the treating clinicians (collectively) should have expertise in transgender-specific diagnostic criteria, mental health, primary care, hormone treatment, and surgery, as needed by the patient. We suggest maintaining physiologic levels of gender-appropriate hormones and monitoring for known risks and complications. When high doses of sex steroids are required to suppress endogenous sex steroids and/or in advanced age, clinicians may consider surgically removing natal gonads along with reducing sex steroid treatment. Clinicians should monitor both transgender males (female to male) and transgender females (male to female) for reproductive organ cancer risk when surgical removal is incomplete. Additionally, clinicians should persistently monitor adverse effects of sex steroids. For gender-affirming surgeries in adults, the treating physician must collaborate with and confirm the criteria for treatment used by the referring physician. Clinicians should avoid harming individuals (via hormone treatment) who have conditions other than gender dysphoria/gender incongruence and who may not benefit from the physical changes associated with this treatment. (*J Clin Endocrinol Metab* 102: 3869–3903, 2017)

Summary of Recommendations

1.0 Evaluation of youth and adults

- 1.1. We advise that only trained mental health professionals (MHPs) who meet the following criteria should diagnose gender dysphoria (GD)/gender incongruence in adults: (1) competence in using the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Statistical Classification of Diseases and Related Health Problems (ICD) for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)
- 1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or the ICD for diagnostic purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psychosocially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)
- 1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).

- 1.4. We recommend against puberty blocking and gender-affirming hormone treatment in pre-pubertal children with GD/gender incongruence. (1 ⊕⊕○○)
- 1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 ⊕⊕⊕○)

2.0 Treatment of adolescents

- 2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment, and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 ⊕⊕○○)
- 2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty. (2 ⊕⊕○○)
- 2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 ⊕⊕○○)
- 2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years. (1 ⊕⊕○○).
- 2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 ⊕○○○)
- 2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment. (2 ⊕⊕○○)

3.0 Hormonal therapy for transgender adults

- 3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and

- the criteria for the endocrine phase of gender transition before beginning treatment. (1 ⊕⊕⊕○)
- 3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment. (1 ⊕⊕⊕○)
- 3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 ⊕⊕○○)
- 3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 ⊕○○○)

4.0 Adverse outcome prevention and long-term care

- 4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every 3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 ⊕⊕○○)
- 4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 ⊕⊕○○)
- 4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 ⊕⊕○○)
- 4.4. We recommend that clinicians obtain bone mineral density (BMD) measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 ⊕⊕○○)
- 4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for non-transgender females. (2 ⊕⊕○○)
- 4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 ⊕○○○)
- 4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

5.0 Surgery for sex reassignment and gender confirmation

- 5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕○○)
- 5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)
- 5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)
- 5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕○○○)
- 5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕○○)
- 5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕○○○)

Changes Since the Previous Guideline

Both the current guideline and the one published in 2009 contain similar sections. Listed here are the sections contained in the current guideline and the corresponding number of recommendations: Introduction, Evaluation of Youth and Adults (5), Treatment of Adolescents (6), Hormonal Therapy for Transgender Adults (4), Adverse Outcomes Prevention and Long-term Care (7), and Surgery for Sex Reassignment and Gender Confirmation (6). The current introduction updates the diagnostic classification of "gender dysphoria/gender incongruence." It also reviews the development of "gender identity" and summarizes its natural development. The section on

clinical evaluation of both youth and adults, defines in detail the professional qualifications required of those who diagnose and treat both adolescents and adults. We advise that decisions regarding the social transition of prepubertal youth are made with the assistance of a mental health professional or similarly experienced professional. We recommend against puberty blocking followed by gender-affirming hormone treatment of prepubertal children. Clinicians should inform pubertal children, adolescents, and adults seeking gender-confirming treatment of their options for fertility preservation. Prior to treatment, clinicians should evaluate the presence of medical conditions that may be worsened by hormone depletion and/or treatment. A multidisciplinary team, preferably composed of medical and mental health professionals, should monitor treatments. Clinicians evaluating transgender adults for endocrine treatment should confirm the diagnosis of persistent gender dysphoria/gender incongruence. Physicians should educate transgender persons regarding the time course of steroid-induced physical changes. Treatment should include periodic monitoring of hormone levels and metabolic parameters, as well as assessments of bone density and the impact upon prostate, gonads, and uterus. We also make recommendations for transgender persons who plan genital gender-affirming surgery.

Method of Development of Evidence-Based Clinical Practice Guidelines

The Clinical Guidelines Subcommittee (CGS) of the Endocrine Society deemed the diagnosis and treatment of individuals with GD/gender incongruence a priority area for revision and appointed a task force to formulate evidence-based recommendations. The task force followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines (1). A detailed description of the grading scheme has been published elsewhere (2). The task force used the best available research evidence to develop the recommendations. The task force also used consistent language and graphical descriptions of both the strength of a recommendation and the quality of evidence. In terms of the strength of the recommendation, strong recommendations use the phrase "we recommend" and the number 1, and weak recommendations use the phrase "we suggest" and the number 2. Cross-filled circles indicate the quality of the evidence, such that ⊕○○○ denotes very low-quality evidence; ⊕⊕○○, low quality; ⊕⊕⊕○, moderate quality; and ⊕⊕⊕⊕, high quality. The task force has confidence that persons who receive care according to the strong recommendations will derive, on average, more benefit than harm. Weak recommendations require more careful consideration of the person's circumstances, values, and preferences to determine the best course of action. Linked to each recommendation is a description of the evidence and the

values that the task force considered in making the recommendation. In some instances, there are remarks in which the task force offers technical suggestions for testing conditions, dosing, and monitoring. These technical comments reflect the best available evidence applied to a typical person being treated. Often this evidence comes from the unsystematic observations of the task force and their preferences; therefore, one should consider these remarks as suggestions.

In this guideline, the task force made several statements to emphasize the importance of shared decision-making, general preventive care measures, and basic principles of the treatment of transgender persons. They labeled these “Ungraded Good Practice Statement.” Direct evidence for these statements was either unavailable or not systematically appraised and considered out of the scope of this guideline. The intention of these statements is to draw attention to these principles.

The Endocrine Society maintains a rigorous conflict-of-interest review process for developing clinical practice guidelines. All task force members must declare any potential conflicts of interest by completing a conflict-of-interest form. The CGS reviews all conflicts of interest before the Society’s Council approves the members to participate on the task force and periodically during the development of the guideline. All others participating in the guideline’s development must also disclose any conflicts of interest in the matter under study, and most of these participants must be without any conflicts of interest. The CGS and the task force have reviewed all disclosures for this guideline and resolved or managed all identified conflicts of interest.

Conflicts of interest are defined as remuneration in any amount from commercial interests; grants; research support; consulting fees; salary; ownership interests [e.g., stocks and stock options (excluding diversified mutual funds)]; honoraria and other payments for participation in speakers’ bureaus, advisory boards, or boards of directors; and all other financial benefits. Completed forms are available through the Endocrine Society office.

The Endocrine Society provided the funding for this guideline; the task force received no funding or remuneration from commercial or other entities.

Commissioned Systematic Review

The task force commissioned two systematic reviews to support this guideline. The first one aimed to summarize the available evidence on the effect of sex steroid use in transgender individuals on lipids and cardiovascular outcomes. The review identified 29 eligible studies at moderate risk of bias. In transgender males (female to male), sex steroid therapy was associated with a statistically significant increase in serum triglycerides and low-density lipoprotein cholesterol levels. High-density lipoprotein cholesterol levels decreased significantly across all follow-up time periods. In transgender females (male to female), serum triglycerides were significantly higher without any changes in other parameters. Few myocardial infarction, stroke, venous thromboembolism (VTE), and death events were reported. These events were more frequent in transgender females. However, the

quality of the evidence was low. The second review summarized the available evidence regarding the effect of sex steroids on bone health in transgender individuals and identified 13 studies. In transgender males, there was no statistically significant difference in the lumbar spine, femoral neck, or total hip BMD at 12 and 24 months compared with baseline values before initiating masculinizing hormone therapy. In transgender females, there was a statistically significant increase in lumbar spine BMD at 12 months and 24 months compared with baseline values before initiation of feminizing hormone therapy. There was minimal information on fracture rates. The quality of evidence was also low.

Introduction

Throughout recorded history (in the absence of an endocrine disorder) some men and women have experienced confusion and anguish resulting from rigid, forced conformity to sexual dimorphism. In modern history, there have been numerous ongoing biological, psychological, cultural, political, and sociological debates over various aspects of gender variance. The 20th century marked the emergence of a social awakening for men and women with the belief that they are “trapped” in the wrong body (3). Magnus Hirschfeld and Harry Benjamin, among others, pioneered the medical responses to those who sought relief from and a resolution to their profound discomfort. Although the term transsexual became widely known after Benjamin wrote “The Transsexual Phenomenon” (4), it was Hirschfeld who coined the term “transsexual” in 1923 to describe people who want to live a life that corresponds with their experienced gender vs their designated gender (5). Magnus Hirschfeld (6) and others (4, 7) have described other types of trans phenomena besides transsexualism. These early researchers proposed that the gender identity of these people was located somewhere along a unidimensional continuum. This continuum ranged from all male through “something in between” to all female. Yet such a classification does not take into account that people may have gender identities outside this continuum. For instance, some experience themselves as having both a male and female gender identity, whereas others completely renounce any gender classification (8, 9). There are also reports of individuals experiencing a continuous and rapid involuntary alternation between a male and female identity (10) or men who do not experience themselves as men but do not want to live as women (11, 12). In some countries, (e.g., Nepal, Bangladesh, and Australia), these nonmale or nonfemale genders are officially recognized (13). Specific treatment protocols, however, have not yet been developed for these groups.

Instead of the term transsexualism, the current classification system of the American Psychiatric Association uses the term gender dysphoria in its diagnosis of persons who are not satisfied with their designated gender (14). The current version of the World Health Organization's ICD-10 still uses the term transsexualism when diagnosing adolescents and adults. However, for the ICD-11, the World Health Organization has proposed using the term "gender incongruence" (15).

Treating persons with GD/gender incongruence (15) was previously limited to relatively ineffective elixirs or creams. However, more effective endocrinology-based treatments became possible with the availability of testosterone in 1935 and diethylstilbestrol in 1938. Reports of individuals with GD/gender incongruence who were treated with hormones and gender-affirming surgery appeared in the press during the second half of the 20th century. The Harry Benjamin International Gender Dysphoria Association was founded in September 1979 and is now called the World Professional Association for Transgender Health (WPATH). WPATH published its first Standards of Care in 1979. These standards have since been regularly updated, providing guidance for treating persons with GD/gender incongruence (16).

Prior to 1975, few peer-reviewed articles were published concerning endocrine treatment of transgender persons. Since then, more than two thousand articles about various aspects of transgender care have appeared.

It is the purpose of this guideline to make detailed recommendations and suggestions, based on existing medical literature and clinical experience, that will enable treating physicians to maximize benefit and minimize risk when caring for individuals diagnosed with GD/gender incongruence.

In the future, we need more rigorous evaluations of the effectiveness and safety of endocrine and surgical protocols. Specifically, endocrine treatment protocols for GD/gender incongruence should include the careful assessment of the following: (1) the effects of prolonged delay of puberty in adolescents on bone health, gonadal function, and the brain (including effects on cognitive, emotional, social, and sexual development); (2) the effects of treatment in adults on sex hormone levels; (3) the requirement for and the effects of progestins and other agents used to suppress endogenous sex steroids during treatment; and (4) the risks and benefits of gender-affirming hormone treatment in older transgender people.

To successfully establish and enact these protocols, a commitment of mental health and endocrine investigators is required to collaborate in long-term, large-scale

studies across countries that use the same diagnostic and inclusion criteria, medications, assay methods, and response assessment tools (e.g., the European Network for the Investigation of Gender Incongruence) (17, 18).

Terminology and its use vary and continue to evolve. Table 1 contains the definitions of terms as they are used throughout this guideline.

Biological Determinants of Gender Identity Development

One's self-awareness as male or female changes gradually during infant life and childhood. This process of cognitive and affective learning evolves with interactions with parents, peers, and environment. A fairly accurate timetable exists outlining the steps in this process (19). Normative psychological literature, however, does not address if and when gender identity becomes crystallized and what factors contribute to the development of a gender identity that is not congruent with the gender of rearing. Results of studies from a variety of biomedical disciplines—genetic, endocrine, and neuroanatomic—support the concept that gender identity and/or gender expression (20) likely reflect a complex interplay of biological, environmental, and cultural factors (21, 22).

With respect to endocrine considerations, studies have failed to find differences in circulating levels of sex steroids between transgender and nontransgender individuals (23). However, studies in individuals with a disorder/difference of sex development (DSD) have informed our understanding of the role that hormones may play in gender identity outcome, even though most persons with GD/gender incongruence do not have a DSD. For example, although most 46,XX adult individuals with virilizing congenital adrenal hyperplasia caused by mutations in *CYP21A2* reported a female gender identity, the prevalence of GD/gender incongruence was much greater in this group than in the general population without a DSD. This supports the concept that there is a role for prenatal/postnatal androgens in gender development (24–26), although some studies indicate that prenatal androgens are more likely to affect gender behavior and sexual orientation rather than gender identity *per se* (27, 28).

Researchers have made similar observations regarding the potential role of androgens in the development of gender identity in other individuals with DSD. For example, a review of two groups of 46,XY persons, each with androgen synthesis deficiencies and female raised, reported transgender male (female-to-male) gender role changes in 56% to 63% and 39% to 64% of patients, respectively (29). Also, in 46,XY female-raised individuals with cloacal

Table 1. Definitions of Terms Used in This Guideline

<i>Biological sex, biological male or female:</i> These terms refer to physical aspects of maleness and femaleness. As these may not be in line with each other (e.g., a person with XY chromosomes may have female-appearing genitalia), the terms biological sex and biological male or female are imprecise and should be avoided.
<i>Cisgender:</i> This means not transgender. An alternative way to describe individuals who are not transgender is “non-transgender people.”
<i>Gender-affirming (hormone) treatment:</i> See “gender reassignment”
<i>Gender dysphoria:</i> This is the distress and unease experienced if gender identity and designated gender are not completely congruent (see Table 2). In 2013, the American Psychiatric Association released the fifth edition of the DSM-5, which replaced “gender identity disorder” with “gender dysphoria” and changed the criteria for diagnosis.
<i>Gender expression:</i> This refers to external manifestations of gender, expressed through one’s name, pronouns, clothing, haircut, behavior, voice, or body characteristics. Typically, transgender people seek to make their gender expression align with their gender identity, rather than their designated gender.
<i>Gender identity/experienced gender:</i> This refers to one’s internal, deeply held sense of gender. For transgender people, their gender identity does not match their sex designated at birth. Most people have a gender identity of man or woman (or boy or girl). For some people, their gender identity does not fit neatly into one of those two choices. Unlike gender expression (see below), gender identity is not visible to others.
<i>Gender identity disorder:</i> This is the term used for GD/gender incongruence in previous versions of DSM (see “gender dysphoria”). The ICD-10 still uses the term for diagnosing child diagnoses, but the upcoming ICD-11 has proposed using “gender incongruence of childhood.”
<i>Gender incongruence:</i> This is an umbrella term used when the gender identity and/or gender expression differs from what is typically associated with the designated gender. Gender incongruence is also the proposed name of the gender identity–related diagnoses in ICD-11. Not all individuals with gender incongruence have gender dysphoria or seek treatment.
<i>Gender variance:</i> See “gender incongruence”
<i>Gender reassignment:</i> This refers to the treatment procedure for those who want to adapt their bodies to the experienced gender by means of hormones and/or surgery. This is also called gender-confirming or gender-affirming treatment.
<i>Gender-reassignment surgery (gender-confirming/gender-affirming surgery):</i> These terms refer only to the surgical part of gender-confirming/gender-affirming treatment.
<i>Gender role:</i> This refers to behaviors, attitudes, and personality traits that a society (in a given culture and historical period) designates as masculine or feminine and/or that society associates with or considers typical of the social role of men or women.
<i>Sex designated at birth:</i> This refers to sex assigned at birth, usually based on genital anatomy.
<i>Sex:</i> This refers to attributes that characterize biological maleness or femaleness. The best known attributes include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, internal and external genitalia, and secondary sex characteristics.
<i>Sexual orientation:</i> This term describes an individual’s enduring physical and emotional attraction to another person. Gender identity and sexual orientation are not the same. Irrespective of their gender identity, transgender people may be attracted to women (gynephilic), attracted to men (androphilic), bisexual, asexual, or queer.
<i>Transgender:</i> This is an umbrella term for people whose gender identity and/or gender expression differs from what is typically associated with their sex designated at birth. Not all transgender individuals seek treatment.
<i>Transgender male (also: trans man, female-to-male, transgender male):</i> This refers to individuals assigned female at birth but who identify and live as men.
<i>Transgender woman (also: trans woman, male-to-female, transgender female):</i> This refers to individuals assigned male at birth but who identify and live as women.
<i>Transition:</i> This refers to the process during which transgender persons change their physical, social, and/or legal characteristics consistent with the affirmed gender identity. Prepubertal children may choose to transition socially.
<i>Transsexual:</i> This is an older term that originated in the medical and psychological communities to refer to individuals who have permanently transitioned through medical interventions or desired to do so.

exstrophy and penile agenesis, the occurrence of transgender male changes was significantly more prevalent than in the general population (30, 31). However, the fact that a high percentage of individuals with the same conditions did not change gender suggests that cultural factors may play a role as well.

With respect to genetics and gender identity, several studies have suggested heritability of GD/gender incongruence (32, 33). In particular, a study by Heylens *et al.* (33) demonstrated a 39.1% concordance rate for gender identity disorder (based on the DSM-IV criteria) in 23 monozygotic twin pairs but no concordance in 21 same-sex dizygotic or seven opposite-sex twin pairs. Although numerous investigators have sought to identify

specific genes associated with GD/gender incongruence, such studies have been inconsistent and without strong statistical significance (34–38).

Studies focusing on brain structure suggest that the brain phenotypes of people with GD/gender incongruence differ in various ways from control males and females, but that there is not a complete sex reversal in brain structures (39).

In summary, although there is much that is still unknown with respect to gender identity and its expression, compelling studies support the concept that biologic factors, in addition to environmental factors, contribute to this fundamental aspect of human development.

Natural History of Children With GD/Gender Incongruence

With current knowledge, we cannot predict the psychosexual outcome for any specific child. Prospective follow-up studies show that childhood GD/gender incongruence does not invariably persist into adolescence and adulthood (so-called “desisters”). Combining all outcome studies to date, the GD/gender incongruence of a minority of prepubertal children appears to persist in adolescence (20, 40). In adolescence, a significant number of these desisters identify as homosexual or bisexual. It may be that children who only showed some gender nonconforming characteristics have been included in the follow-up studies, because the DSM-IV text revision criteria for a diagnosis were rather broad. However, the persistence of GD/gender incongruence into adolescence is more likely if it had been extreme in childhood (41, 42). With the newer, stricter criteria of the DSM-5 (Table 2), persistence rates may well be different in future studies.

1.0 Evaluation of Youth and Adults

Gender-affirming treatment is a multidisciplinary effort. After evaluation, education, and diagnosis, treatment may include mental health care, hormone therapy, and/or surgical therapy. Together with an MHP, hormone-prescribing clinicians should examine the psychosocial impact of the potential changes on people’s lives, including mental health, friends, family, jobs, and their role in society. Transgender individuals should be encouraged to experience living in the new gender role and assess whether

this improves their quality of life. Although the focus of this guideline is gender-affirming hormone therapy, collaboration with appropriate professionals responsible for each aspect of treatment maximizes a successful outcome.

Diagnostic assessment and mental health care

GD/gender incongruence may be accompanied with psychological or psychiatric problems (43–51). It is therefore necessary that clinicians who prescribe hormones and are involved in diagnosis and psychosocial assessment meet the following criteria: (1) are competent in using the DSM and/or the ICD for diagnostic purposes, (2) are able to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) are trained in diagnosing psychiatric conditions, (4) undertake or refer for appropriate treatment, (5) are able to do a psychosocial assessment of the patient’s understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) regularly attend relevant professional meetings.

Because of the psychological vulnerability of many individuals with GD/gender incongruence, it is important that mental health care is available before, during, and sometimes also after transitioning. For children and adolescents, an MHP who has training/experience in child and adolescent gender development (as well as child and adolescent psychopathology) should make the diagnosis, because assessing GD/gender incongruence in children and adolescents is often extremely complex.

During assessment, the clinician obtains information from the individual seeking gender-affirming treatment. In the case

Table 2. DSM-5 Criteria for Gender Dysphoria in Adolescents and Adults

- A. A marked incongruence between one’s experienced/expressed gender and natal gender of at least 6 mo in duration, as manifested by at least two of the following:
 1. A marked incongruence between one’s experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics)
 2. A strong desire to be rid of one’s primary and/or secondary sex characteristics because of a marked incongruence with one’s experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics)
 3. A strong desire for the primary and/or secondary sex characteristics of the other gender
 4. A strong desire to be of the other gender (or some alternative gender different from one’s designated gender)
 5. A strong desire to be treated as the other gender (or some alternative gender different from one’s designated gender)
 6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one’s designated gender)
 - B. The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- Specify if:
1. The condition exists with a disorder of sex development.
 2. The condition is posttransitional, in that the individual has transitioned to full-time living in the desired gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one sex-related medical procedure or treatment regimen—namely, regular sex hormone treatment or gender reassignment surgery confirming the desired gender (*e.g.*, penectomy, vaginoplasty in natal males; mastectomy or phalloplasty in natal females).

of adolescents, the clinician also obtains information from the parents or guardians regarding various aspects of the child's general and psychosexual development and current functioning. On the basis of this information, the clinician:

- decides whether the individual fulfills criteria for treatment (see Tables 2 and 3) for GD/gender incongruence (DSM-5) or transsexualism (DSM-5 and/or ICD-10);
- informs the individual about the possibilities and limitations of various kinds of treatment (hormonal/surgical and nonhormonal), and if medical treatment is desired, provides correct information to prevent unrealistically high expectations;
- assesses whether medical interventions may result in unfavorable psychological and social outcomes.

In cases in which severe psychopathology, circumstances, or both seriously interfere with the diagnostic work or make satisfactory treatment unlikely, clinicians should assist the adolescent in managing these other issues. Literature on postoperative regret suggests that besides poor quality of surgery, severe psychiatric comorbidity and lack of support may interfere with positive outcomes (52–56).

For adolescents, the diagnostic procedure usually includes a complete psychodiagnostic assessment (57) and an assessment of the decision-making capability of the youth. An evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the adolescent's situation should be part of the diagnostic phase (58).

Social transitioning

A change in gender expression and role (which may involve living part time or full time in another gender role that is consistent with one's gender identity) may test the person's resolve, the capacity to function in the affirmed gender, and the adequacy of social, economic, and psychological supports. It assists both the individual and the clinician in their judgments about how to proceed (16). During social transitioning, the person's feelings about the social transformation (including coping with the responses of others) is a major focus of the counseling. The optimal timing for social transitioning may differ between individuals. Sometimes people wait until they

start gender-affirming hormone treatment to make social transitioning easier, but individuals increasingly start social transitioning long before they receive medically supervised, gender-affirming hormone treatment.

Criteria

Adolescents and adults seeking gender-affirming hormone treatment and surgery should satisfy certain criteria before proceeding (16). Criteria for gender-affirming hormone therapy for adults are in Table 4, and criteria for gender-affirming hormone therapy for adolescents are in Table 5. Follow-up studies in adults meeting these criteria indicate a high satisfaction rate with treatment (59). However, the quality of evidence is usually low. A few follow-up studies on adolescents who fulfilled these criteria also indicated good treatment results (60–63).

Recommendations for Those Involved in the Gender-Affirming Hormone Treatment of Individuals With GD/Gender Incongruence

- 1.1. We advise that only trained MHPs who meet the following criteria should diagnose GD/gender incongruence in adults: (1) competence in using the DSM and/or the ICD for diagnostic purposes, (2) the ability to diagnose GD/gender incongruence and make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (3) training in diagnosing psychiatric conditions, (4) the ability to undertake or refer for appropriate treatment, (5) the ability to psychosocially assess the person's understanding, mental health, and social conditions that can impact gender-affirming hormone therapy, and (6) a practice of regularly attending relevant professional meetings. (Ungraded Good Practice Statement)
- 1.2. We advise that only MHPs who meet the following criteria should diagnose GD/gender incongruence in children and adolescents: (1) training in child and adolescent developmental psychology and psychopathology, (2) competence in using the DSM and/or ICD for diagnostic

Table 3. ICD-10 Criteria for Transsexualism

Transsexualism (F64.0) has three criteria:

1. The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatments.
2. The transsexual identity has been present persistently for at least 2 y.
3. The disorder is not a symptom of another mental disorder or a genetic, DSD, or chromosomal abnormality.

Table 4. Criteria for Gender-Affirming Hormone Therapy for Adults

1. Persistent, well-documented gender dysphoria/gender incongruence
2. The capacity to make a fully informed decision and to consent for treatment
3. The age of majority in a given country (if younger, follow the criteria for adolescents)
4. Mental health concerns, if present, must be reasonably well controlled

Reproduced from World Professional Association for Transgender Health (16).

purposes, (3) the ability to make a distinction between GD/gender incongruence and conditions that have similar features (*e.g.*, body dysmorphic disorder), (4) training in diagnosing psychiatric conditions, (5) the ability to undertake or refer for appropriate treatment, (6) the ability to psycho-socially assess the person's understanding and social conditions that can impact gender-affirming hormone therapy, (7) a practice of regularly attending relevant professional meetings, and (8) knowledge of the criteria for puberty blocking and gender-affirming hormone treatment in adolescents. (Ungraded Good Practice Statement)

Evidence

Individuals with gender identity issues may have psychological or psychiatric problems (43–48, 50, 51, 64, 65). It is therefore necessary that clinicians making the diagnosis are able to make a distinction between GD/gender incongruence and conditions that have similar features. Examples of conditions with similar features are body dysmorphic disorder, body identity integrity disorder (a condition in which individuals have a sense that their anatomical configuration as an able-bodied person is somehow wrong or inappropriate) (66), or certain forms of eunuchism (in which a person is preoccupied with or engages in castration and/or penectomy for

Table 5. Criteria for Gender-Affirming Hormone Therapy for Adolescents

Adolescents are eligible for GnRH agonist treatment if:

1. A qualified MHP has confirmed that:
 - the adolescent has demonstrated a long-lasting and intense pattern of gender nonconformity or gender dysphoria (whether suppressed or expressed),
 - gender dysphoria worsened with the onset of puberty,
 - any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start treatment,
 - the adolescent has sufficient mental capacity to give informed consent to this (reversible) treatment,
2. And the adolescent:
 - has been informed of the effects and side effects of treatment (including potential loss of fertility if the individual subsequently continues with sex hormone treatment) and options to preserve fertility,
 - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
3. And a pediatric endocrinologist or other clinician experienced in pubertal assessment:
 - agrees with the indication for GnRH agonist treatment,
 - has confirmed that puberty has started in the adolescent (Tanner stage \geq G2/B2),
 - has confirmed that there are no medical contraindications to GnRH agonist treatment.

Adolescents are eligible for subsequent sex hormone treatment if:

1. A qualified MHP has confirmed:
 - the persistence of gender dysphoria,
 - any coexisting psychological, medical, or social problems that could interfere with treatment (*e.g.*, that may compromise treatment adherence) have been addressed, such that the adolescent's situation and functioning are stable enough to start sex hormone treatment,
 - the adolescent has sufficient mental capacity (which most adolescents have by age 16 years) to estimate the consequences of this (partly) irreversible treatment, weigh the benefits and risks, and give informed consent to this (partly) irreversible treatment,
2. And the adolescent:
 - has been informed of the (irreversible) effects and side effects of treatment (including potential loss of fertility and options to preserve fertility),
 - has given informed consent and (particularly when the adolescent has not reached the age of legal medical consent, depending on applicable legislation) the parents or other caretakers or guardians have consented to the treatment and are involved in supporting the adolescent throughout the treatment process,
3. And a pediatric endocrinologist or other clinician experienced in pubertal induction:
 - agrees with the indication for sex hormone treatment,
 - has confirmed that there are no medical contraindications to sex hormone treatment.

Reproduced from World Professional Association for Transgender Health (16).

reasons that are not gender identity related) (11). Clinicians should also be able to diagnose psychiatric conditions accurately and ensure that these conditions are treated appropriately, particularly when the conditions may complicate treatment, affect the outcome of gender-affirming treatment, or be affected by hormone use.

Values and preferences

The task force placed a very high value on avoiding harm from hormone treatment in individuals who have conditions other than GD/gender incongruence and who may not benefit from the physical changes associated with this treatment and placed a low value on any potential benefit these persons believe they may derive from hormone treatment. This justifies the good practice statement.

- 1.3. We advise that decisions regarding the social transition of prepubertal youths with GD/gender incongruence are made with the assistance of an MHP or another experienced professional. (Ungraded Good Practice Statement).
- 1.4. We recommend against puberty blocking and gender-affirming hormone treatment in prepubertal children with GD/gender incongruence. (1 ⊕⊕○○)

Evidence

In most children diagnosed with GD/gender incongruence, it did not persist into adolescence. The percentages differed among studies, probably dependent on which version of the DSM clinicians used, the patient's age, the recruitment criteria, and perhaps cultural factors. However, the large majority (about 85%) of prepubertal children with a childhood diagnosis did not remain GD/gender incongruent in adolescence (20). If children have completely socially transitioned, they may have great difficulty in returning to the original gender role upon entering puberty (40). Social transition is associated with the persistence of GD/gender incongruence as a child progresses into adolescence. It may be that the presence of GD/gender incongruence in prepubertal children is the earliest sign that a child is destined to be transgender as an adolescent/adult (20). However, social transition (in addition to GD/gender incongruence) has been found to contribute to the likelihood of persistence.

This recommendation, however, does not imply that children should be discouraged from showing gender-variant behaviors or should be punished for exhibiting such behaviors. In individual cases, an early complete social transition may result in a more favorable outcome, but there are currently no criteria to identify the

GD/gender-incongruent children to whom this applies. At the present time, clinical experience suggests that persistence of GD/gender incongruence can only be reliably assessed after the first signs of puberty.

Values and preferences

The task force placed a high value on avoiding harm with gender-affirming hormone therapy in prepubertal children with GD/gender incongruence. This justifies the strong recommendation in the face of low-quality evidence.

- 1.5. We recommend that clinicians inform and counsel all individuals seeking gender-affirming medical treatment regarding options for fertility preservation prior to initiating puberty suppression in adolescents and prior to treating with hormonal therapy of the affirmed gender in both adolescents and adults. (1 ⊕⊕⊕○)

Remarks

Persons considering hormone use for gender affirmation need adequate information about this treatment in general and about fertility effects of hormone treatment in particular to make an informed and balanced decision (67, 68). Because young adolescents may not feel qualified to make decisions about fertility and may not fully understand the potential effects of hormonal interventions, consent and protocol education should include parents, the referring MHP(s), and other members of the adolescent's support group. To our knowledge, there are no formally evaluated decision aids available to assist in the discussion and decision regarding the future fertility of adolescents or adults beginning gender-affirming treatment.

Treating early pubertal youth with GnRH analogs will temporarily impair spermatogenesis and oocyte maturation. Given that an increasing number of transgender youth want to preserve fertility potential, delaying or temporarily discontinuing GnRH analogs to promote gamete maturation is an option. This option is often not preferred, because mature sperm production is associated with later stages of puberty and with the significant development of secondary sex characteristics.

For those designated male at birth with GD/gender incongruence and who are in early puberty, sperm production and the development of the reproductive tract are insufficient for the cryopreservation of sperm. However, prolonged pubertal suppression using GnRH analogs is reversible and clinicians should inform these individuals that sperm production can be initiated following prolonged gonadotropin suppression. This can be accomplished by spontaneous gonadotropin recovery after

cessation of GnRH analogs or by gonadotropin treatment and will probably be associated with physical manifestations of testosterone production, as stated above. Note that there are no data in this population concerning the time required for sufficient spermatogenesis to collect enough sperm for later fertility. In males treated for precocious puberty, spermarche was reported 0.7 to 3 years after cessation of GnRH analogs (69). In adult men with gonadotropin deficiency, sperm are noted in seminal fluid by 6 to 12 months of gonadotropin treatment. However, sperm numbers when partners of these patients conceive are far below the “normal range” (70, 71).

In girls, no studies have reported long-term, adverse effects of pubertal suppression on ovarian function after treatment cessation (72, 73). Clinicians should inform adolescents that no data are available regarding either time to spontaneous ovulation after cessation of GnRH analogs or the response to ovulation induction following prolonged gonadotropin suppression.

In males with GD/gender incongruence, when medical treatment is started in a later phase of puberty or in adulthood, spermatogenesis is sufficient for cryopreservation and storage of sperm. *In vitro* spermatogenesis is currently under investigation. Restoration of spermatogenesis after prolonged estrogen treatment has not been studied.

In females with GD/gender incongruence, the effect of prolonged treatment with exogenous testosterone on ovarian function is uncertain. There have been reports of an increased incidence of polycystic ovaries in transgender males, both prior to and as a result of androgen treatment (74–77), although these reports were not confirmed by others (78). Pregnancy has been reported in transgender males who have had prolonged androgen treatment and have discontinued testosterone but have not had genital surgery (79, 80). A reproductive endocrine gynecologist can counsel patients before gender-affirming hormone treatment or surgery regarding potential fertility options (81). Techniques for cryopreservation of oocytes, embryos, and ovarian tissue continue to improve, and oocyte maturation of immature tissue is being studied (82).

2.0 Treatment of Adolescents

During the past decade, clinicians have progressively acknowledged the suffering of young adolescents with GD/gender incongruence. In some forms of GD/gender incongruence, psychological interventions may be useful and sufficient. However, for many adolescents with GD/gender incongruence, the pubertal physical changes are unbearable. As early medical intervention may prevent

psychological harm, various clinics have decided to start treating young adolescents with GD/gender incongruence with puberty-suppressing medication (a GnRH analog). As compared with starting gender-affirming treatment long after the first phases of puberty, a benefit of pubertal suppression at early puberty may be a better psychological and physical outcome.

In girls, the first physical sign of puberty is the budding of the breasts followed by an increase in breast and fat tissue. Breast development is also associated with the pubertal growth spurt, and menarche occurs ~2 years later. In boys, the first physical change is testicular growth. A testicular volume ≥ 4 mL is seen as consistent with the initiation of physical puberty. At the beginning of puberty, estradiol and testosterone levels are still low and are best measured in the early morning with an ultrasensitive assay. From a testicular volume of 10 mL, daytime testosterone levels increase, leading to virilization (83). Note that pubic hair and/or axillary hair/odor may not reflect the onset of gonadarche; instead, it may reflect adrenarche alone.

- 2.1. We suggest that adolescents who meet diagnostic criteria for GD/gender incongruence, fulfill criteria for treatment (Table 5), and are requesting treatment should initially undergo treatment to suppress pubertal development. (2 $\oplus\oplus\oplus\oplus$)
- 2.2. We suggest that clinicians begin pubertal hormone suppression after girls and boys first exhibit physical changes of puberty (Tanner stages G2/B2). (2 $\oplus\oplus\oplus\oplus$)

Evidence

Pubertal suppression can expand the diagnostic phase by a long period, giving the subject more time to explore options and to live in the experienced gender before making a decision to proceed with gender-affirming sex hormone treatments and/or surgery, some of which is irreversible (84, 85). Pubertal suppression is fully reversible, enabling full pubertal development in the natal gender, after cessation of treatment, if appropriate. The experience of full endogenous puberty is an undesirable condition for the GD/gender-incongruent individual and may seriously interfere with healthy psychological functioning and well-being. Treating GD/gender-incongruent adolescents entering puberty with GnRH analogs has been shown to improve psychological functioning in several domains (86).

Another reason to start blocking pubertal hormones early in puberty is that the physical outcome is improved compared with initiating physical transition after puberty has been completed (60, 62). Looking like a man or woman when living as the opposite sex creates difficult

barriers with enormous life-long disadvantages. We therefore advise starting suppression in early puberty to prevent the irreversible development of undesirable secondary sex characteristics. However, adolescents with GD/gender incongruence should experience the first changes of their endogenous spontaneous puberty, because their emotional reaction to these first physical changes has diagnostic value in establishing the persistence of GD/gender incongruence (85). Thus, Tanner stage 2 is the optimal time to start pubertal suppression. However, pubertal suppression treatment in early puberty will limit the growth of the penis and scrotum, which will have a potential effect on future surgical treatments (87).

Clinicians can also use pubertal suppression in adolescents in later pubertal stages to stop menses in transgender males and prevent facial hair growth in transgender females. However, in contrast to the effects in early pubertal adolescents, physical sex characteristics (such as more advanced breast development in transgender boys and lowering of the voice and outgrowth of the jaw and brow in transgender girls) are not reversible.

Values and preferences

These recommendations place a high value on avoiding an unsatisfactory physical outcome when secondary sex characteristics have become manifest and irreversible, a higher value on psychological well-being, and a lower value on avoiding potential harm from early pubertal suppression.

Remarks

Table 6 lists the Tanner stages of breast and male genital development. Careful documentation of hallmarks of pubertal development will ensure precise timing when initiating pubertal suppression once puberty has started. Clinicians can use pubertal LH and sex steroid levels to confirm that puberty has progressed sufficiently before starting pubertal suppression (88). Reference

ranges for sex steroids by Tanner stage may vary depending on the assay used. Ultrasensitive sex steroid and gonadotropin assays will help clinicians document early pubertal changes.

Irreversible and, for GD/gender-incongruent adolescents, undesirable sex characteristics in female puberty are breasts, female body habitus, and, in some cases, relative short stature. In male puberty, they are a prominent Adam's apple; low voice; male bone configuration, such as a large jaw, big feet and hands, and tall stature; and male hair pattern on the face and extremities.

- 2.3. We recommend that, where indicated, GnRH analogues are used to suppress pubertal hormones. (1 ⊕ ⊕ ⊕ ⊕)

Evidence

Clinicians can suppress pubertal development and gonadal function most effectively via gonadotropin suppression using GnRH analogs. GnRH analogs are long-acting agonists that suppress gonadotropins by GnRH receptor desensitization after an initial increase of gonadotropins during ~10 days after the first and (to a lesser degree) the second injection (89). Antagonists immediately suppress pituitary gonadotropin secretion (90, 91). Long-acting GnRH analogs are the currently preferred treatment option. Clinicians may consider long-acting GnRH antagonists when evidence on their safety and efficacy in adolescents becomes available.

During GnRH analog treatment, slight development of secondary sex characteristics may regress, and in a later phase of pubertal development, it will stop. In girls, breast tissue will become atrophic, and menses will stop. In boys, virilization will stop, and testicular volume may decrease (92).

An advantage of using GnRH analogs is the reversibility of the intervention. If, after extensive exploration of his/her transition wish, the individual no longer desires transition, they can discontinue pubertal suppression. In subjects with

Table 6. Tanner Stages of Breast Development and Male External Genitalia

The description of Tanner stages for breast development:

1. Prepubertal
2. Breast and papilla elevated as small mound; areolar diameter increased
3. Breast and areola enlarged, no contour separation
4. Areola and papilla form secondary mound
5. Mature; nipple projects, areola part of general breast contour

For penis and testes:

1. Prepubertal, testicular volume <4 mL
2. Slight enlargement of penis; enlarged scrotum, pink, texture altered, testes 4–6 mL
3. Penis longer, testes larger (8–12 mL)
4. Penis and glans larger, including increase in breadth; testes larger (12–15 mL), scrotum dark
5. Penis adult size; testicular volume > 15 mL

precocious puberty, spontaneous pubertal development has been shown to resume after patients discontinue taking GnRH analogs (93).

Recommendations 2.1 to 2.3 are supported by a prospective follow-up study from The Netherlands. This report assessed mental health outcomes in 55 transgender adolescents/young adults (22 transgender females and 33 transgender males) at three time points: (1) before the start of GnRH agonist (average age of 14.8 years at start of treatment), (2) at initiation of gender-affirming hormones (average age of 16.7 years at start of treatment), and (3) 1 year after “gender-reassignment surgery” (average age of 20.7 years) (63). Despite a decrease in depression and an improvement in general mental health functioning, GD/gender incongruence persisted through pubertal suppression, as previously reported (86). However, following sex hormone treatment and gender-reassignment surgery, GD/gender incongruence was resolved and psychological functioning steadily improved (63). Furthermore, well-being was similar to or better than that reported by age-matched young adults from the general population, and none of the study participants regretted treatment. This study represents the first long-term follow-up of individuals managed according to currently existing clinical practice guidelines for transgender youth, and it underscores the benefit of the multidisciplinary approach pioneered in The Netherlands; however, further studies are needed.

Side effects

The primary risks of pubertal suppression in GD/gender-incongruent adolescents may include adverse effects on bone mineralization (which can theoretically be reversed with sex hormone treatment), compromised fertility if the person subsequently is treated with sex hormones, and unknown effects on brain development. Few data are available on the effect of GnRH analogs on BMD in adolescents with GD/gender incongruence. Initial data in GD/gender-incongruent subjects demonstrated no change of absolute areal BMD during 2 years of GnRH analog therapy but a decrease in BMD z scores (85). A recent study also suggested suboptimal bone mineral accrual during GnRH analog treatment. The study reported a decrease in areal BMD z scores and of bone mineral apparent density z scores (which takes the size of the bone into account) in 19 transgender males treated with GnRH analogs from a mean age of 15.0 years (standard deviation = 2.0 years) for a median duration of 1.5 years (0.3 to 5.2 years) and in 15 transgender females treated from 14.9 (± 1.9) years for 1.3 years (0.5 to 3.8 years), although not all changes were statistically significant (94). There was incomplete catch-up at age 22 years after sex hormone treatment from age 16.6 (± 1.4)

years for a median duration of 5.8 years (3.0 to 8.0 years) in transgender females and from age 16.4 (± 2.3) years for 5.4 years (2.8 to 7.8 years) in transgender males. Little is known about more prolonged use of GnRH analogs. Researchers reported normal BMD z scores at age 35 years in one individual who used GnRH analogs from age 13.7 years until age 18.6 years before initiating sex hormone treatment (65).

Additional data are available from individuals with late puberty or GnRH analog treatment of other indications. Some studies reported that men with constitutionally delayed puberty have decreased BMD in adulthood (95). However, other studies reported that these men have normal BMD (96, 97). Treating adults with GnRH analogs results in a decrease of BMD (98). In children with central precocious puberty, treatment with GnRH analogs has been found to result in a decrease of BMD during treatment by some (99) but not others (100). Studies have reported normal BMD after discontinuing therapy (69, 72, 73, 101, 102). In adolescents treated with growth hormone who are small for gestational age and have normal pubertal timing, 2-year GnRH analog treatments did not adversely affect BMD (103). Calcium supplementation may be beneficial in optimizing bone health in GnRH analog-treated individuals (104). There are no studies of vitamin D supplementation in this context, but clinicians should offer supplements to vitamin D-deficient adolescents. Physical activity, especially during growth, is important for bone mass in healthy individuals (103) and is therefore likely to be beneficial for bone health in GnRH analog-treated subjects.

GnRH analogs did not induce a change in body mass index standard deviation score in GD/gender-incongruent adolescents (94) but caused an increase in fat mass and decrease in lean body mass percentage (92). Studies in girls treated for precocious puberty also reported a stable body mass index standard deviation score during treatment (72) and body mass index and body composition comparable to controls after treatment (73).

Arterial hypertension has been reported as an adverse effect in a few girls treated with GnRH analogs for precocious/early puberty (105, 106). Blood pressure monitoring before and during treatment is recommended.

Individuals may also experience hot flashes, fatigue, and mood alterations as a consequence of pubertal suppression. There is no consensus on treatment of these side effects in this context.

It is recommended that any use of pubertal blockers (and subsequent use of sex hormones, as detailed below) include a discussion about implications for fertility (see recommendation 1.3). Transgender adolescents may

want to preserve fertility, which may be otherwise compromised if puberty is suppressed at an early stage and the individual completes phenotypic transition with the use of sex hormones.

Limited data are available regarding the effects of GnRH analogs on brain development. A single cross-sectional study demonstrated no compromise of executive function (107), but animal data suggest there may be an effect of GnRH analogs on cognitive function (108).

Values and preferences

Our recommendation of GnRH analogs places a higher value on the superior efficacy, safety, and reversibility of the pubertal hormone suppression achieved (as compared with the alternatives) and a relatively lower value on limiting the cost of therapy. Of the available alternatives, depot and oral progestin preparations are effective. Experience with this treatment dates back prior to the emergence of GnRH analogs for treating precocious puberty in papers from the 1960s and early 1970s (109–112). These compounds are usually safe, but some side effects have been reported (113–115). Only two recent studies involved transgender youth (116, 117). One of these studies described the use of oral lynestrenol monotherapy followed by the addition of testosterone treatment in transgender boys who were at Tanner stage B4 or further at the start of treatment (117). They found lynestrenol safe, but gonadotropins were not fully suppressed. The study reported metrorrhagia in approximately half of the individuals, mainly in the first 6 months. Acne, headache, hot flashes, and fatigue were other frequent side effects. Another progestin that has been studied in the United States is medroxyprogesterone. This agent is not as effective as GnRH analogs in lowering endogenous sex hormones either and may be associated with other side effects (116). Progestin preparations may be an acceptable treatment for persons without access to GnRH analogs or with a needle phobia. If GnRH analog treatment is not available (insurance denial, prohibitive cost, or other reasons), postpubertal, transgender female adolescents may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see adult section).

Remarks

Measurements of gonadotropin and sex steroid levels give precise information about gonadal axis suppression, although there is insufficient evidence for any specific short-term monitoring scheme in children treated with GnRH analogs (88). If the gonadal axis is not completely suppressed—as evidenced by (for example) menses, erections, or progressive hair growth—the interval of GnRH analog treatment can be shortened or the dose increased. During treatment, adolescents should be monitored for negative effects of delaying puberty, including a halted growth spurt and impaired bone mineral accretion. Table 7 illustrates a suggested clinical protocol.

Anthropometric measurements and X-rays of the left hand to monitor bone age are informative for evaluating growth. To assess BMD, clinicians can perform dual-energy X-ray absorptiometry scans.

- 2.4. In adolescents who request sex hormone treatment (given this is a partly irreversible treatment), we recommend initiating treatment using a gradually increasing dose schedule (see Table 8) after a multidisciplinary team of medical and MHPs has confirmed the persistence of GD/gender incongruence and sufficient mental capacity to give informed consent, which most adolescents have by age 16 years (Table 5). (1 ⊕⊕○○)
- 2.5. We recognize that there may be compelling reasons to initiate sex hormone treatment prior to the age of 16 years in some adolescents with GD/gender incongruence, even though there are minimal published studies of gender-affirming hormone treatments administered before age 13.5 to 14 years. As with the care of adolescents ≥16 years of age, we recommend that an expert multidisciplinary team of medical and MHPs manage this treatment. (1 ⊕○○○)
- 2.6. We suggest monitoring clinical pubertal development every 3 to 6 months and laboratory parameters every 6 to 12 months during sex hormone treatment (Table 9). (2 ⊕⊕○○)

Table 7. Baseline and Follow-Up Protocol During Suppression of Puberty

Every 3–6 mo
Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
Every 6–12 mo
Laboratory: LH, FSH, E2/T, 25OH vitamin D
Every 1–2 y
Bone density using DXA
Bone age on X-ray of the left hand (if clinically indicated)

Adapted from Hembree *et al.* (118).

Abbreviations: DXA, dual-energy X-ray absorptiometry; E2, estradiol; FSH, follicle stimulating hormone; LH, luteinizing hormone; T, testosterone;

Table 8. Protocol Induction of Puberty

Induction of female puberty with oral 17β -estradiol, increasing the dose every 6 mo:
 5 $\mu\text{g/kg/d}$
 10 $\mu\text{g/kg/d}$
 15 $\mu\text{g/kg/d}$
 20 $\mu\text{g/kg/d}$
 Adult dose = 2–6 mg/d
In postpubertal transgender female adolescents, the dose of 17β -estradiol can be increased more rapidly:
 1 mg/d for 6 mo
 2 mg/d
 Induction of female puberty with transdermal 17β -estradiol, increasing the dose every 6 mo (new patch is placed every 3.5 d):
 6.25–12.5 $\mu\text{g/24 h}$ (cut 25- μg patch into quarters, then halves)
 25 $\mu\text{g/24 h}$
 37.5 $\mu\text{g/24 h}$
 Adult dose = 50–200 $\mu\text{g/24 h}$
For alternatives once at adult dose, see Table 11.
Adjust maintenance dose to mimic physiological estradiol levels (see Table 15).
 Induction of male puberty with testosterone esters increasing the dose every 6 mo (IM or SC):
 25 $\text{mg/m}^2/2 \text{ wk}$ (or alternatively, half this dose weekly, or double the dose every 4 wk)
 50 $\text{mg/m}^2/2 \text{ wk}$
 75 $\text{mg/m}^2/2 \text{ wk}$
 100 $\text{mg/m}^2/2 \text{ wk}$
 Adult dose = 100–200 mg every 2 wk
In postpubertal transgender male adolescents the dose of testosterone esters can be increased more rapidly:
 75 mg/2 wk for 6 mo
 125 mg/2 wk
For alternatives once at adult dose, see Table 11.
Adjust maintenance dose to mimic physiological testosterone levels (see Table 14).

Adapted from Hembree et al. (118).

Abbreviations: IM, intramuscularly; SC, subcutaneously.

Evidence

Adolescents develop competence in decision making at their own pace. Ideally, the supervising medical professionals should individually assess this competence, although no objective tools to make such an assessment are currently available.

Many adolescents have achieved a reasonable level of competence by age 15 to 16 years (119), and in many countries 16-year-olds are legally competent with regard to medical decision making (120). However, others believe that although some capacities are generally achieved before age 16 years, other abilities (such as good risk

assessment) do not develop until well after 18 years (121). They suggest that health care procedures should be divided along a matrix of relative risk, so that younger adolescents can be allowed to decide about low-risk procedures, such as most diagnostic tests and common therapies, but not about high-risk procedures, such as most surgical procedures (121).

Currently available data from transgender adolescents support treatment with sex hormones starting at age 16 years (63, 122). However, some patients may incur potential risks by waiting until age 16 years. These include the potential risk to bone health if puberty is suppressed

Table 9. Baseline and Follow-up Protocol During Induction of Puberty

Every 3–6 mo
 •Anthropometry: height, weight, sitting height, blood pressure, Tanner stages
 Every 6–12 mo
 •In transgender males: hemoglobin/hematocrit, lipids, testosterone, 25OH vitamin D
 •In transgender females: prolactin, estradiol, 25OH vitamin D
 Every 1–2 y
 •BMD using DXA
 •Bone age on X-ray of the left hand (if clinically indicated)
BMD should be monitored into adulthood (until the age of 25–30 y or until peak bone mass has been reached).
For recommendations on monitoring once pubertal induction has been completed, see Tables 14 and 15.

Adapted from Hembree et al. (118).

Abbreviation: DXA, dual-energy X-ray absorptiometry.

for 6 to 7 years before initiating sex hormones (*e.g.*, if someone reached Tanner stage 2 at age 9-10 years old). Additionally, there may be concerns about inappropriate height and potential harm to mental health (emotional and social isolation) if initiation of secondary sex characteristics must wait until the person has reached 16 years of age. However, only minimal data supporting earlier use of gender-affirming hormones in transgender adolescents currently exist (63). Clearly, long-term studies are needed to determine the optimal age of sex hormone treatment in GD/gender-incongruent adolescents.

The MHP who has followed the adolescent during GnRH analog treatment plays an essential role in assessing whether the adolescent is eligible to start sex hormone therapy and capable of consenting to this treatment (Table 5). Support of the family/environment is essential. Prior to the start of sex hormones, clinicians should discuss the implications for fertility (see recommendation 1.5). Throughout pubertal induction, an MHP and a pediatric endocrinologist (or other clinician competent in the evaluation and induction of pubertal development) should monitor the adolescent. In addition to monitoring therapy, it is also important to pay attention to general adolescent health issues, including healthy life style choices, such as not smoking, contraception, and appropriate vaccinations (*e.g.*, human papillomavirus).

For the induction of puberty, clinicians can use a similar dose scheme for hypogonadal adolescents with GD/gender incongruence as they use in other individuals with hypogonadism, carefully monitoring for desired and undesired effects (Table 8). In transgender female adolescents, transdermal 17β -estradiol may be an alternative for oral 17β -estradiol. It is increasingly used for pubertal induction in hypogonadal females. However, the absence of low-dose estrogen patches may be a problem. As a result, individuals may need to cut patches to size themselves to achieve appropriate dosing (123). In transgender male adolescents, clinicians can give testosterone injections intramuscularly or subcutaneously (124, 125).

When puberty is initiated with a gradually increasing schedule of sex steroid doses, the initial levels will not be high enough to suppress endogenous sex steroid secretion. Gonadotropin secretion and endogenous production of testosterone may resume and interfere with the effectiveness of estrogen treatment, in transgender female adolescents (126, 127). Therefore, continuation of GnRH analog treatment is advised until gonadectomy. Given that GD/gender-incongruent adolescents may opt not to have gonadectomy, long-term studies are necessary to examine the potential risks of prolonged GnRH analog treatment. Alternatively, in transgender male adolescents, GnRH analog treatment can be discontinued once an

adult dose of testosterone has been reached and the individual is well virilized. If uterine bleeding occurs, a progestin can be added. However, the combined use of a GnRH analog (for ovarian suppression) and testosterone may enable phenotypic transition with a lower dose of testosterone in comparison with testosterone alone. If there is a wish or need to discontinue GnRH analog treatment in transgender female adolescents, they may be treated with an antiandrogen that directly suppresses androgen synthesis or action (see section 3.0 “Hormonal Therapy for Transgender Adults”).

Values and preferences

The recommendation to initiate pubertal induction only when the individual has sufficient mental capacity (roughly age 16 years) to give informed consent for this partly irreversible treatment places a higher value on the ability of the adolescent to fully understand and oversee the partially irreversible consequences of sex hormone treatment and to give informed consent. It places a lower value on the possible negative effects of delayed puberty. We may not currently have the means to weigh adequately the potential benefits of waiting until around age 16 years to initiate sex hormones vs the potential risks/harm to BMD and the sense of social isolation from having the timing of puberty be so out of sync with peers (128).

Remarks

Before starting sex hormone treatment, effects on fertility and options for fertility preservation should be discussed. Adult height may be a concern in transgender adolescents. In a transgender female adolescent, clinicians may consider higher doses of estrogen or a more rapid tempo of dose escalation during pubertal induction. There are no established treatments yet to augment adult height in a transgender male adolescent with open epiphyses during pubertal induction. It is not uncommon for transgender adolescents to present for clinical services after having completed or nearly completed puberty. In such cases, induction of puberty with sex hormones can be done more rapidly (see Table 8). Additionally, an adult dose of testosterone in transgender male adolescents may suffice to suppress the gonadal axis without the need to use a separate agent. At the appropriate time, the multidisciplinary team should adequately prepare the adolescent for transition to adult care.

3.0 Hormonal Therapy for Transgender Adults

The two major goals of hormonal therapy are (1) to reduce endogenous sex hormone levels, and thus reduce

the secondary sex characteristics of the individual's designated gender, and (2) to replace endogenous sex hormone levels consistent with the individual's gender identity by using the principles of hormone replacement treatment of hypogonadal patients. The timing of these two goals and the age at which to begin treatment with the sex hormones of the chosen gender is codetermined in collaboration with both the person pursuing transition and the health care providers. The treatment team should include a medical provider knowledgeable in transgender hormone therapy, an MHP knowledgeable in GD/gender incongruence and the mental health concerns of transition, and a primary care provider able to provide care appropriate for transgender individuals. The physical changes induced by this sex hormone transition are usually accompanied by an improvement in mental well-being (129, 130).

- 3.1. We recommend that clinicians confirm the diagnostic criteria of GD/gender incongruence and the criteria for the endocrine phase of gender transition before beginning treatment. (1 ⊕⊕⊕⊕)
- 3.2. We recommend that clinicians evaluate and address medical conditions that can be exacerbated by hormone depletion and treatment with sex hormones of the affirmed gender before beginning treatment (Table 10). (1 ⊕⊕⊕⊕)
- 3.3. We suggest that clinicians measure hormone levels during treatment to ensure that endogenous sex steroids are suppressed and administered sex steroids are maintained in the normal physiologic range for the affirmed gender. (2 ⊕⊕⊕⊕)

Evidence

It is the responsibility of the treating clinician to confirm that the person fulfills criteria for treatment. The treating clinician should become familiar with the terms and criteria presented in Tables 1–5 and take a thorough history from the patient in collaboration with the other members of the treatment team. The treating clinician must ensure that the desire for transition is appropriate; the consequences, risks, and benefits of treatment are well understood; and the desire for transition persists. They also need to discuss fertility preservation options (see recommendation 1.3) (67, 68).

Transgender males

Clinical studies have demonstrated the efficacy of several different androgen preparations to induce masculinization in transgender males (Appendix A) (113, 114, 131–134). Regimens to change secondary sex characteristics follow the general principle of hormone replacement treatment of male hypogonadism (135). Clinicians can use either parenteral or transdermal preparations to achieve testosterone values in the normal male range (this is dependent on the specific assay, but is typically 320 to 1000 ng/dL) (Table 11) (136). Sustained supraphysiologic levels of testosterone increase the risk of adverse reactions (see section 4.0 “Adverse Outcome Prevention and Long-Term Care”) and should be avoided.

Similar to androgen therapy in hypogonadal men, testosterone treatment in transgender males results in increased muscle mass and decreased fat mass, increased facial hair and acne, male pattern baldness in those genetically predisposed, and increased sexual desire (137).

Table 10. Medical Risks Associated With Sex Hormone Therapy

Transgender female: estrogen

Very high risk of adverse outcomes:

- Thromboembolic disease

Moderate risk of adverse outcomes:

- Macroprolactinoma
- Breast cancer
- Coronary artery disease
- Cerebrovascular disease
- Cholelithiasis
- Hypertriglyceridemia

Transgender male: testosterone

Very high risk of adverse outcomes:

- Erythrocytosis (hematocrit > 50%)

Moderate risk of adverse outcomes:

- Severe liver dysfunction (transaminases > threefold upper limit of normal)
- Coronary artery disease
- Cerebrovascular disease
- Hypertension
- Breast or uterine cancer

Table 11. Hormone Regimens in Transgender Persons

Transgender females ^a	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch	0.025–0.2 mg/d
(New patch placed every 3–5 d)	
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate ^b	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly
Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate ^c	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6% ^d	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d

Abbreviations: IM, intramuscularly; SQ, sequentially; SC, subcutaneously.

^aEstrogens used with or without antiandrogens or GnRH agonist.

^bNot available in the United States.

^cOne thousand milligrams initially followed by an injection at 6 wk then at 12-wk intervals.

^dAvoid cutaneous transfer to other individuals.

In transgender males, testosterone will result in clitoromegaly, temporary or permanent decreased fertility, deepening of the voice, cessation of menses (usually), and a significant increase in body hair, particularly on the face, chest, and abdomen. Cessation of menses may occur within a few months with testosterone treatment alone, although high doses of testosterone may be required. If uterine bleeding continues, clinicians may consider the addition of a progestational agent or endometrial ablation (138). Clinicians may also administer GnRH analogs or depot medroxyprogesterone to stop menses prior to testosterone treatment.

Transgender females

The hormone regimen for transgender females is more complex than the transgender male regimen (Appendix B). Treatment with physiologic doses of estrogen alone is insufficient to suppress testosterone levels into the normal range for females (139). Most published clinical studies report the need for adjunctive therapy to achieve testosterone levels in the female range (21, 113, 114, 132–134, 139, 140).

Multiple adjunctive medications are available, such as progestins with antiandrogen activity and GnRH agonists (141). Spironolactone works by directly blocking androgens during their interaction with the androgen

receptor (114, 133, 142). It may also have estrogenic activity (143). Cyproterone acetate, a progestational compound with antiandrogenic properties (113, 132, 144), is widely used in Europe. 5 α -Reductase inhibitors do not reduce testosterone levels and have adverse effects (145).

Dittrich *et al.* (141) reported that monthly doses of the GnRH agonist goserelin acetate in combination with estrogen were effective in reducing testosterone levels with a low incidence of adverse reactions in 60 transgender females. Leuprolide and transdermal estrogen were as effective as cyproterone and transdermal estrogen in a comparative retrospective study (146).

Patients can take estrogen as oral conjugated estrogens, oral 17 β -estradiol, or transdermal 17 β -estradiol. Among estrogen options, the increased risk of thromboembolic events associated with estrogens in general seems most concerning with ethinyl estradiol specifically (134, 140, 141), which is why we specifically suggest that it not be used in any transgender treatment plan. Data distinguishing among other estrogen options are less well established although there is some thought that oral routes of administration are more thrombogenic due to the “first pass effect” than are transdermal and parenteral routes, and that the risk of thromboembolic events is dose-dependent. Injectable estrogen and sublingual

estrogen may benefit from avoiding the first pass effect, but they can result in more rapid peaks with greater overall periodicity and thus are more difficult to monitor (147, 148). However, there are no data demonstrating that increased periodicity is harmful otherwise.

Clinicians can use serum estradiol levels to monitor oral, transdermal, and intramuscular estradiol. Blood tests cannot monitor conjugated estrogens or synthetic estrogen use. Clinicians should measure serum estradiol and serum testosterone and maintain them at the level for premenopausal females (100 to 200 pg/mL and <50 ng/dL, respectively). The transdermal preparations and injectable estradiol cypionate or valerate preparations may confer an advantage in older transgender females who may be at higher risk for thromboembolic disease (149).

Values

Our recommendation to maintain levels of gender-affirming hormones in the normal adult range places a high value on the avoidance of the long-term complications of pharmacologic doses. Those patients receiving endocrine treatment who have relative contraindications to hormones should have an in-depth discussion with their physician to balance the risks and benefits of therapy.

Remarks

Clinicians should inform all endocrine-treated individuals of all risks and benefits of gender-affirming hormones prior to initiating therapy. Clinicians should strongly encourage tobacco use cessation in transgender females to avoid increased risk of VTE and cardiovascular complications. We strongly discourage the unsupervised use of hormone therapy (150).

Not all individuals with GD/gender incongruence seek treatment as described (e.g., male-to-eunuchs and individuals seeking partial transition). Tailoring current protocols to the individual may be done within the context of accepted safety guidelines using a multidisciplinary approach including mental health. No evidence-based protocols are available for these groups (151). We need prospective studies to better understand treatment options for these persons.

- 3.4. We suggest that endocrinologists provide education to transgender individuals undergoing treatment about the onset and time course of physical changes induced by sex hormone treatment. (2 ⊕○○○)

Evidence

Transgender males

Physical changes that are expected to occur during the first 1 to 6 months of testosterone therapy include

cessation of menses, increased sexual desire, increased facial and body hair, increased oiliness of skin, increased muscle, and redistribution of fat mass. Changes that occur within the first year of testosterone therapy include deepening of the voice (152, 153), clitoromegaly, and male pattern hair loss (in some cases) (114, 144, 154, 155) (Table 12).

Transgender females

Physical changes that may occur in transgender females in the first 3 to 12 months of estrogen and anti-androgen therapy include decreased sexual desire, decreased spontaneous erections, decreased facial and body hair (usually mild), decreased oiliness of skin, increased breast tissue growth, and redistribution of fat mass (114, 139, 149, 154, 155, 161) (Table 13). Breast development is generally maximal at 2 years after initiating hormones (114, 139, 149, 155). Over a long period of time, the prostate gland and testicles will undergo atrophy.

Although the time course of breast development in transgender females has been studied (150), precise information about other changes induced by sex hormones is lacking (141). There is a great deal of variability among individuals, as evidenced during pubertal development. We all know that a major concern for transgender females is breast development. If we work with estrogens, the result will be often not what the transgender female expects.

Alternatively, there are transgender females who report an anecdotal improved breast development, mood, or sexual desire with the use of progestogens. However, there have been no well-designed studies of the role of progestogens in feminizing hormone regimens, so the question is still open.

Our knowledge concerning the natural history and effects of different cross-sex hormone therapies on breast

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	— ^a
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	— ^b
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Estimates represent clinical observations: Toorians *et al.* (149), Assche-man *et al.* (156), Gooren *et al.* (157), Wierckx *et al.* (158).

^aPrevention and treatment as recommended for biological men.

^bMenorrhagia requires diagnosis and treatment by a gynecologist.

Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y ^a
Scalp hair	Variable	— ^b
Voice changes	None	— ^c

Estimates represent clinical observations: Toorians *et al.* (149), Asscheman *et al.* (156), Gooren *et al.* (157).

^aComplete removal of male sexual hair requires electrolysis or laser treatment or both.

^bFamilial scalp hair loss may occur if estrogens are stopped.

^cTreatment by speech pathologists for voice training is most effective.

development in transgender females is extremely sparse and based on the low quality of evidence. Current evidence does not indicate that progestogens enhance breast development in transgender females, nor does evidence prove the absence of such an effect. This prevents us from drawing any firm conclusion at this moment and demonstrates the need for further research to clarify these important clinical questions (162).

Values and preferences

Transgender persons have very high expectations regarding the physical changes of hormone treatment and are aware that body changes can be enhanced by surgical procedures (*e.g.*, breast, face, and body habitus). Clear expectations for the extent and timing of sex hormone-induced changes may prevent the potential harm and expense of unnecessary procedures.

4.0 Adverse Outcome Prevention and Long-Term Care

Hormone therapy for transgender males and females confers many of the same risks associated with sex hormone replacement therapy in nontransgender persons. The risks arise from and are worsened by inadvertent or intentional use of supraphysiologic doses of sex hormones, as well as use of inadequate doses of sex hormones to maintain normal physiology (131, 139).

- 4.1. We suggest regular clinical evaluation for physical changes and potential adverse changes in response to sex steroid hormones and laboratory monitoring of sex steroid hormone levels every

3 months during the first year of hormone therapy for transgender males and females and then once or twice yearly. (2 ⊕⊕○○)

Evidence

Pretreatment screening and appropriate regular medical monitoring are recommended for both transgender males and females during the endocrine transition and periodically thereafter (26, 155). Clinicians should monitor weight and blood pressure, conduct physical exams, and assess routine health questions, such as tobacco use, symptoms of depression, and risk of adverse events such as deep vein thrombosis/pulmonary embolism and other adverse effects of sex steroids.

Transgender males

Table 14 contains a standard monitoring plan for transgender males on testosterone therapy (154, 159). Key issues include maintaining testosterone levels in the physiologic normal male range and avoiding adverse events resulting from excess testosterone therapy, particularly erythrocytosis, sleep apnea, hypertension, excessive weight gain, salt retention, lipid changes, and excessive or cystic acne (135).

Because oral 17-alkylated testosterone is not recommended, serious hepatic toxicity is not anticipated with parenteral or transdermal testosterone use (163, 164). Past concerns regarding liver toxicity with testosterone have been alleviated with subsequent reports that indicate the risk of serious liver disease is minimal (144, 165, 166).

Transgender females

Table 15 contains a standard monitoring plan for transgender females on estrogens, gonadotropin suppression, or antiandrogens (160). Key issues include avoiding supraphysiologic doses or blood levels of estrogen that may lead to increased risk for thromboembolic disease, liver dysfunction, and hypertension. Clinicians should monitor serum estradiol levels using laboratories participating in external quality control, as measurements of estradiol in blood can be very challenging (167).

VTE may be a serious complication. A study reported a 20-fold increase in venous thromboembolic disease in a large cohort of Dutch transgender subjects (161). This increase may have been associated with the use of the synthetic estrogen, ethinyl estradiol (149). The incidence decreased when clinicians stopped administering ethinyl estradiol (161). Thus, the use of synthetic estrogens and conjugated estrogens is undesirable because of the inability to regulate doses by measuring serum levels and the risk of thromboembolic disease. In a German gender clinic, deep vein thrombosis occurred in 1 of 60 of transgender females treated with a GnRH analog and oral

Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:^a
 - a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
 - b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
 - c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

^aAdapted from Lapauw *et al.* (154) and Ott *et al.* (159).

estradiol (141). The patient who developed a deep vein thrombosis was found to have a homozygous C677 T mutation in the methylenetetrahydrofolate reductase gene. In an Austrian gender clinic, administering gender-affirming hormones to 162 transgender females and 89 transgender males was not associated with VTE, despite an 8.0% and 5.6% incidence of thrombophilia (159). A more recent multinational study reported only 10 cases of VTE from a cohort of 1073 subjects (168). Thrombophilia screening of transgender persons initiating hormone treatment should be restricted to those with a personal or family history of VTE (159). Monitoring D-dimer levels during treatment is not recommended (169).

- 4.2. We suggest periodically monitoring prolactin levels in transgender females treated with estrogens. (2 ⊕⊕○○)

Evidence

Estrogen therapy can increase the growth of pituitary lactotroph cells. There have been several reports of prolactinomas occurring after long-term, high-dose

estrogen therapy (170–173). Up to 20% of transgender females treated with estrogens may have elevations in prolactin levels associated with enlargement of the pituitary gland (156). In most cases, the serum prolactin levels will return to the normal range with a reduction or discontinuation of the estrogen therapy or discontinuation of cyproterone acetate (157, 174, 175).

The onset and time course of hyperprolactinemia during estrogen treatment are not known. Clinicians should measure prolactin levels at baseline and then at least annually during the transition period and every 2 years thereafter. Given that only a few case studies reported prolactinomas, and prolactinomas were not reported in large cohorts of estrogen-treated persons, the risk is likely to be very low. Because the major presenting findings of microprolactinomas (hypogonadism and sometimes gynecomastia) are not apparent in transgender females, clinicians may perform radiologic examinations of the pituitary in those patients whose prolactin levels persistently increase despite stable or reduced estrogen levels. Some transgender individuals receive psychotropic medications that can increase prolactin levels (174).

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
 - a. Serum testosterone levels should be <50 ng/dL.
 - b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

- 4.3. We suggest that clinicians evaluate transgender persons treated with hormones for cardiovascular risk factors using fasting lipid profiles, diabetes screening, and/or other diagnostic tools. (2 |⊕⊕○○)

Evidence

Transgender males

Administering testosterone to transgender males results in a more atherogenic lipid profile with lowered high-density lipoprotein cholesterol and higher triglyceride and low-density lipoprotein cholesterol values (176–179). Studies of the effect of testosterone on insulin sensitivity have mixed results (178, 180). A randomized, open-label uncontrolled safety study of transgender males treated with testosterone undecanoate demonstrated no insulin resistance after 1 year (181, 182). Numerous studies have demonstrated the effects of sex hormone treatment on the cardiovascular system (160, 179, 183, 184). Long-term studies from The Netherlands found no increased risk for cardiovascular mortality (161). Likewise, a meta-analysis of 19 randomized trials in nontransgender males on testosterone replacement showed no increased incidence of cardiovascular events (185). A systematic review of the literature found that data were insufficient (due to very low-quality evidence) to allow a meaningful assessment of patient-important outcomes, such as death, stroke, myocardial infarction, or VTE in transgender males (176). Future research is needed to ascertain the potential harm of hormonal therapies (176). Clinicians should manage cardiovascular risk factors as they emerge according to established guidelines (186).

Transgender females

A prospective study of transgender females found favorable changes in lipid parameters with increased high-density lipoprotein and decreased low-density lipoprotein concentrations (178). However, increased weight, blood pressure, and markers of insulin resistance attenuated these favorable lipid changes. In a meta-analysis, only serum triglycerides were higher at ≥24 months without changes in other parameters (187). The largest cohort of transgender females (mean age 41 years, followed for a mean of 10 years) showed no increase in cardiovascular mortality despite a 32% rate of tobacco use (161).

Thus, there is limited evidence to determine whether estrogen is protective or detrimental on lipid and glucose metabolism in transgender females (176). With aging, there is usually an increase of body weight. Therefore, as with nontransgender individuals, clinicians should

monitor and manage glucose and lipid metabolism and blood pressure regularly according to established guidelines (186).

- 4.4. We recommend that clinicians obtain BMD measurements when risk factors for osteoporosis exist, specifically in those who stop sex hormone therapy after gonadectomy. (1 |⊕⊕○○)

Evidence

Transgender males

Baseline bone mineral measurements in transgender males are generally in the expected range for their pre-treatment gender (188). However, adequate dosing of testosterone is important to maintain bone mass in transgender males (189, 190). In one study (190), serum LH levels were inversely related to BMD, suggesting that low levels of sex hormones were associated with bone loss. Thus, LH levels in the normal range may serve as an indicator of the adequacy of sex steroid administration to preserve bone mass. The protective effect of testosterone may be mediated by peripheral conversion to estradiol, both systemically and locally in the bone.

Transgender females

A baseline study of BMD reported T scores less than −2.5 in 16% of transgender females (191). In aging males, studies suggest that serum estradiol more positively correlates with BMD than does testosterone (192, 193) and is more important for peak bone mass (194). Estrogen preserves BMD in transgender females who continue on estrogen and antiandrogen therapies (188, 190, 191, 195, 196).

Fracture data in transgender males and females are not available. Transgender persons who have undergone gonadectomy may choose not to continue consistent sex steroid treatment after hormonal and surgical sex reassignment, thereby becoming at risk for bone loss. There have been no studies to determine whether clinicians should use the sex assigned at birth or affirmed gender for assessing osteoporosis (e.g., when using the FRAX tool). Although some researchers use the sex assigned at birth (with the assumption that bone mass has usually peaked for transgender people who initiate hormones in early adulthood), this should be assessed on a case-by-case basis until there are more data available. This assumption will be further complicated by the increasing prevalence of transgender people who undergo hormonal transition at a pubertal age or soon after puberty. Sex for comparison within risk assessment tools may be based on the age at which hormones were initiated and the length of exposure to hormones. In some cases, it may be

reasonable to assess risk using both the male and female calculators and using an intermediate value. Because all subjects underwent normal pubertal development, with known effects on bone size, reference values for birth sex were used for all participants (154).

- 4.5. We suggest that transgender females with no known increased risk of breast cancer follow breast-screening guidelines recommended for those designated female at birth. (2 ⊕⊕⊕⊕)
- 4.6. We suggest that transgender females treated with estrogens follow individualized screening according to personal risk for prostatic disease and prostate cancer. (2 ⊕⊕⊕⊕)

Evidence

Studies have reported a few cases of breast cancer in transgender females (197–200). A Dutch study of 1800 transgender females followed for a mean of 15 years (range of 1–30 years) found one case of breast cancer. The Women's Health Initiative study reported that females taking conjugated equine estrogen without progesterone for 7 years did not have an increased risk of breast cancer as compared with females taking placebo (137).

In transgender males, a large retrospective study conducted at the U.S. Veterans Affairs medical health system identified seven breast cancers (194). The authors reported that this was not above the expected rate of breast cancers in cisgender females in this cohort. Furthermore, they did report one breast cancer that developed in a transgender male patient after mastectomy, supporting the fact that breast cancer can occur even after mastectomy. Indeed, there have been case reports of breast cancer developing in subareolar tissue in transgender males, which occurred after mastectomy (201, 202).

Women with primary hypogonadism (Turner syndrome) treated with estrogen replacement exhibited a significantly decreased incidence of breast cancer as compared with national standardized incidence ratios (203, 204). These studies suggest that estrogen therapy does not increase the risk of breast cancer in the short term (<20 to 30 years). We need long-term studies to determine the actual risk, as well as the role of screening mammograms. Regular examinations and gynecologic advice should determine monitoring for breast cancer.

Prostate cancer is very rare before the age of 40, especially with androgen deprivation therapy (205). Childhood or pubertal castration results in regression of the prostate and adult castration reverses benign prostate hypertrophy (206). Although van Kesteren *et al.* (207) reported that estrogen therapy does not induce hypertrophy or premalignant changes in the prostates of

transgender females, studies have reported cases of benign prostatic hyperplasia in transgender females treated with estrogens for 20 to 25 years (208, 209). Studies have also reported a few cases of prostate carcinoma in transgender females (210–214).

Transgender females may feel uncomfortable scheduling regular prostate examinations. Gynecologists are not trained to screen for prostate cancer or to monitor prostate growth. Thus, it may be reasonable for transgender females who transitioned after age 20 years to have annual screening digital rectal examinations after age 50 years and prostate-specific antigen tests consistent with U.S. Preventive Services Task Force Guidelines (215).

- 4.7. We advise that clinicians determine the medical necessity of including a total hysterectomy and oophorectomy as part of gender-affirming surgery. (Ungraded Good Practice Statement)

Evidence

Although aromatization of testosterone to estradiol in transgender males has been suggested as a risk factor for endometrial cancer (216), no cases have been reported. When transgender males undergo hysterectomy, the uterus is small and there is endometrial atrophy (217, 218). Studies have reported cases of ovarian cancer (219, 220). Although there is limited evidence for increased risk of reproductive tract cancers in transgender males, health care providers should determine the medical necessity of a laparoscopic total hysterectomy as part of a gender-affirming surgery to prevent reproductive tract cancer (221).

Values

Given the discomfort that transgender males experience accessing gynecologic care, our recommendation for the medical necessity of total hysterectomy and oophorectomy places a high value on eliminating the risks of female reproductive tract disease and cancer and a lower value on avoiding the risks of these surgical procedures (related to the surgery and to the potential undesirable health consequences of oophorectomy) and their associated costs.

Remarks

The sexual orientation and type of sexual practices will determine the need and types of gynecologic care required following transition. Additionally, in certain countries, the approval required to change the sex in a birth certificate for transgender males may be dependent on having a complete hysterectomy. Clinicians should help patients research nonmedical administrative criteria and

provide counseling. If individuals decide not to undergo hysterectomy, screening for cervical cancer is the same as all other females.

5.0 Surgery for Sex Reassignment and Gender Confirmation

For many transgender adults, genital gender-affirming surgery may be the necessary step toward achieving their ultimate goal of living successfully in their desired gender role. The type of surgery falls into two main categories: (1) those that directly affect fertility and (2) those that do not. Those that change fertility (previously called sex reassignment surgery) include genital surgery to remove the penis and gonads in the male and removal of the uterus and gonads in the female. The surgeries that effect fertility are often governed by the legal system of the state or country in which they are performed. Other gender-conforming surgeries that do not directly affect fertility are not so tightly governed.

Gender-affirming surgical techniques have improved markedly during the past 10 years. Reconstructive genital surgery that preserves neurologic sensation is now the standard. The satisfaction rate with surgical reassignment of sex is now very high (187). Additionally, the mental health of the individual seems to be improved by participating in a treatment program that defines a pathway of gender-affirming treatment that includes hormones and surgery (130, 144) (Table 16).

Surgery that affects fertility is irreversible. The World Professional Association for Transgender Health Standards of Care (222) emphasizes that the “threshold of 18 should not be seen as an indication in itself for active intervention.” If the social transition has not been satisfactory, if the person is not satisfied with or is ambivalent about the effects of sex hormone treatment, or if the person is ambivalent about surgery then the individual should not be referred for surgery (223, 224).

Gender-affirming genital surgeries for transgender females that affect fertility include gonadectomy, penectomy, and creation of a neovagina (225, 226). Surgeons often invert the skin of the penis to form the wall of the vagina, and several literatures reviews have

reported on outcomes (227). Sometimes there is inadequate tissue to form a full neovagina, so clinicians have revisited using intestine and found it to be successful (87, 228, 229). Some newer vaginoplasty techniques may involve autologous oral epithelial cells (230, 231).

The scrotum becomes the labia majora. Surgeons use reconstructive surgery to fashion the clitoris and its hood, preserving the neurovascular bundle at the tip of the penis as the neurosensory supply to the clitoris. Some surgeons are also creating a sensate pedicled-spot adding a G spot to the neovagina to increase sensation (232). Most recently, plastic surgeons have developed techniques to fashion labia minora. To further complete the feminization, uterine transplants have been proposed and even attempted (233).

Neovaginal prolapse, rectovaginal fistula, delayed healing, vaginal stenosis, and other complications do sometimes occur (234, 235). Clinicians should strongly remind the transgender person to use their dilators to maintain the depth and width of the vagina throughout the postoperative period. Genital sexual responsivity and other aspects of sexual function are usually preserved following genital gender-affirming surgery (236, 237).

Ancillary surgeries for more feminine or masculine appearance are not within the scope of this guideline. Voice therapy by a speech language pathologist is available to transform speech patterns to the affirmed gender (148). Spontaneous voice deepening occurs during testosterone treatment of transgender males (152, 238). No studies have compared the effectiveness of speech therapy, laryngeal surgery, or combined treatment.

Breast surgery is a good example of gender-confirming surgery that does not affect fertility. In all females, breast size exhibits a very broad spectrum. For transgender females to make the best informed decision, clinicians should delay breast augmentation surgery until the patient has completed at least 2 years of estrogen therapy, because the breasts continue to grow during that time (141, 155).

Another major procedure is the removal of facial and masculine-appearing body hair using either electrolysis or

Table 16. Criteria for Gender-Affirming Surgery, Which Affects Fertility

1. Persistent, well-documented gender dysphoria
2. Legal age of majority in the given country
3. Having continuously and responsibly used gender-affirming hormones for 12 mo (if there is no medical contraindication to receiving such therapy)
4. Successful continuous full-time living in the new gender role for 12 mo
5. If significant medical or mental health concerns are present, they must be well controlled
6. Demonstrable knowledge of all practical aspects of surgery (e.g., cost, required lengths of hospitalizations, likely complications, postsurgical rehabilitation)

laser treatments. Other feminizing surgeries, such as that to feminize the face, are now becoming more popular (239–241).

In transgender males, clinicians usually delay gender-affirming genital surgeries until after a few years of androgen therapy. Those surgeries that affect fertility in this group include oophorectomy, vaginectomy, and complete hysterectomy. Surgeons can safely perform them vaginally with laparoscopy. These are sometimes done in conjunction with the creation of a neopenis. The cosmetic appearance of a neopenis is now very good, but the surgery is multistage and very expensive (242, 243). Radial forearm flap seems to be the most satisfactory procedure (228, 244). Other flaps also exist (245). Surgeons can make neopenile erections possible by reinnervation of the flap and subsequent contraction of the muscle, leading to stiffening of the neopenis (246, 247), but results are inconsistent (248). Surgeons can also stiffen the penis by imbedding some mechanical device (*e.g.*, a rod or some inflatable apparatus) (249, 250). Because of these limitations, the creation of a neopenis has often been less than satisfactory. Recently, penis transplants are being proposed (233).

In fact, most transgender males do not have any external genital surgery because of the lack of access, high cost, and significant potential complications. Some choose a metaoidioplasty that brings forward the clitoris, thereby allowing them to void in a standing position without wetting themselves (251, 252). Surgeons can create the scrotum from the labia majora with good cosmetic effect and can implant testicular prostheses (253).

The most important masculinizing surgery for the transgender male is mastectomy, and it does not affect fertility. Breast size only partially regresses with androgen therapy (155). In adults, discussions about mastectomy usually take place after androgen therapy has started. Because some transgender male adolescents present after significant breast development has occurred, they may also consider mastectomy 2 years after they begin androgen therapy and before age 18 years. Clinicians should individualize treatment based on the physical and mental health status of the individual. There are now newer approaches to mastectomy with better outcomes (254, 255). These often involve chest contouring (256). Mastectomy is often necessary for living comfortably in the new gender (256).

- 5.1. We recommend that a patient pursue genital gender-affirming surgery only after the MHP and the clinician responsible for endocrine transition therapy both agree that surgery is medically

necessary and would benefit the patient's overall health and/or well-being. (1 ⊕⊕○○)

- 5.2. We advise that clinicians approve genital gender-affirming surgery only after completion of at least 1 year of consistent and compliant hormone treatment, unless hormone therapy is not desired or medically contraindicated. (Ungraded Good Practice Statement)
- 5.3. We advise that the clinician responsible for endocrine treatment and the primary care provider ensure appropriate medical clearance of transgender individuals for genital gender-affirming surgery and collaborate with the surgeon regarding hormone use during and after surgery. (Ungraded Good Practice Statement)
- 5.4. We recommend that clinicians refer hormone-treated transgender individuals for genital surgery when: (1) the individual has had a satisfactory social role change, (2) the individual is satisfied about the hormonal effects, and (3) the individual desires definitive surgical changes. (1 ⊕○○○)
- 5.5. We suggest that clinicians delay gender-affirming genital surgery involving gonadectomy and/or hysterectomy until the patient is at least 18 years old or legal age of majority in his or her country. (2 ⊕⊕○○)
- 5.6. We suggest that clinicians determine the timing of breast surgery for transgender males based upon the physical and mental health status of the individual. There is insufficient evidence to recommend a specific age requirement. (2 ⊕○○○)

Evidence

Owing to the lack of controlled studies, incomplete follow-up, and lack of valid assessment measures, evaluating various surgical approaches and techniques is difficult. However, one systematic review including a large numbers of studies reported satisfactory cosmetic and functional results for vaginoplasty/neovagina construction (257). For transgender males, the outcomes are less certain. However, the problems are now better understood (258). Several postoperative studies report significant long-term psychological and psychiatric pathology (259–261). One study showed satisfaction with breasts, genitals, and femininity increased significantly and showed the importance of surgical treatment as a key therapeutic option for transgender females (262). Another analysis demonstrated that, despite the young average age at death following surgery and the relatively larger number of individuals with somatic morbidity, the study does not allow for determination of

causal relationships between, for example, specific types of hormonal or surgical treatment received and somatic morbidity and mortality (263). Reversal surgery in regretful male-to-female transsexuals after sexual reassignment surgery represents a complex, multistage procedure with satisfactory outcomes. Further insight into the characteristics of persons who regret their decision postoperatively would facilitate better future selection of applicants eligible for sexual reassignment surgery. We need more studies with appropriate controls that examine long-term quality of life, psychosocial outcomes, and psychiatric outcomes to determine the long-term benefits of surgical treatment.

When a transgender individual decides to have gender-affirming surgery, both the hormone prescribing clinician and the MHP must certify that the patient satisfies criteria for gender-affirming surgery (Table 16).

There is some concern that estrogen therapy may cause an increased risk for venous thrombosis during or following surgery (176). For this reason, the surgeon and the hormone-prescribing clinician should collaborate in making a decision about the use of hormones before and following surgery. One study suggests that preoperative factors (such as compliance) are less important for patient satisfaction than are the physical postoperative results (56). However, other studies and clinical experience dictate that individuals who do not follow medical instructions and do not work with their physicians toward a common goal do not achieve treatment goals (264) and experience higher rates of postoperative infections and other complications (265, 266). It is also important that the person requesting surgery feels comfortable with the anatomical changes that have occurred during hormone therapy. Dissatisfaction with social and physical outcomes during the hormone transition may be a contraindication to surgery (223).

An endocrinologist or experienced medical provider should monitor transgender individuals after surgery. Those who undergo gonadectomy will require hormone replacement therapy, surveillance, or both to prevent adverse effects of chronic hormone deficiency.

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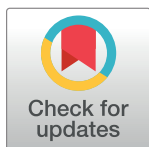
RESEARCH ARTICLE

Parent reports of adolescents and young adults perceived to show signs of a rapid onset of gender dysphoria

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Abstract

Purpose

In on-line forums, parents have reported that their children seemed to experience a sudden or rapid onset of gender dysphoria, appearing for the first time during puberty or even after its completion. Parents describe that the onset of gender dysphoria seemed to occur in the context of belonging to a peer group where one, multiple, or even all of the friends have become gender dysphoric and transgender-identified during the same timeframe. Parents also report that their children exhibited an increase in social media/internet use prior to disclosure of a transgender identity. Recently, clinicians have reported that post-puberty presentations of gender dysphoria in natal females that appear to be rapid in onset is a phenomenon that they are seeing more and more in their clinic. Academics have raised questions about the role of social media in the development of gender dysphoria. The purpose of this study was to collect data about parents' observations, experiences, and perspectives about their adolescent and young adult (AYA) children showing signs of an apparent sudden or rapid onset of gender dysphoria that began during or after puberty, and develop hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among this demographic group.

Methods

For this descriptive, exploratory study, recruitment information with a link to a 90-question survey, consisting of multiple-choice, Likert-type and open-ended questions was placed on three websites where parents had reported sudden or rapid onsets of gender dysphoria occurring in their teen or young adult children. The study's eligibility criteria included parental response that their child had a sudden or rapid onset of gender dysphoria and parental indication that their child's gender dysphoria began during or after puberty. To maximize the chances of finding cases meeting eligibility criteria, the three websites (4thwavenow, transgender trend, and youthtranscriticalprofessionals) were selected for targeted recruitment. Website moderators and potential participants were encouraged to share the recruitment information and link to the survey with any individuals or communities that they thought

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Data Availability Statement: The data cannot be made available due to ethical and regulatory restrictions. The study participants did not provide consent to have their responses shared publicly, shared in public databases, or shared with outside researchers. The Program for the Protection of Human Subjects (PPHS) at the Icahn School of Medicine at Mount Sinai is not permitting the sharing of data beyond what is reported in the paper owing to the sensitive nature of the collected information, the context of the study topic, its release's possible impact on the participants' reputation and standing in the community, and the

risk of participant recognition through linkage of details. As participants' identifiers were not collected it is not possible to contact participants and ask for their consent to disclose at this time. For any questions about restriction on data sharing, please contact PPHS at the Icahn School of Medicine at Mount Sinai (IRB@mssm.edu).

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Competing interests: Lisa Littman, MD, MPH, provides public health consulting on topics unrelated to this research. She is a member of several professional organizations including the American College of Preventive Medicine (ACPM), the American Public Health Association (APHA), the Society for Adolescent Health and Medicine (SAHM), the Society of Family Planning (SFP), the International Academy of Sex Research (IASR), and the World Professional Association for Transgender Health (WPATH).

might include eligible participants to expand the reach of the project through snowball sampling techniques. Data were collected anonymously via SurveyMonkey. Quantitative findings are presented as frequencies, percentages, ranges, means and/or medians. Open-ended responses from two questions were targeted for qualitative analysis of themes.

Results

There were 256 parent-completed surveys that met study criteria. The AYA children described were predominantly natal female (82.8%) with a mean age of 16.4 years at the time of survey completion and a mean age of 15.2 when they announced a transgender-identification. Per parent report, 41% of the AYAs had expressed a non-heterosexual sexual orientation before identifying as transgender. Many (62.5%) of the AYAs had reportedly been diagnosed with at least one mental health disorder or neurodevelopmental disability prior to the onset of their gender dysphoria (range of the number of pre-existing diagnoses 0–7). In 36.8% of the friendship groups described, parent participants indicated that the majority of the members became transgender-identified. Parents reported subjective declines in their AYAs' mental health (47.2%) and in parent-child relationships (57.3%) since the AYA "came out" and that AYAs expressed a range of behaviors that included: expressing distrust of non-transgender people (22.7%); stopping spending time with non-transgender friends (25.0%); trying to isolate themselves from their families (49.4%), and only trusting information about gender dysphoria from transgender sources (46.6%). Most (86.7%) of the parents reported that, along with the sudden or rapid onset of gender dysphoria, their child either had an increase in their social media/internet use, belonged to a friend group in which one or multiple friends became transgender-identified during a similar time-frame, or both

Conclusion

This descriptive, exploratory study of parent reports provides valuable detailed information that allows for the generation of hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among AYAs. Emerging hypotheses include the possibility of a potential new subcategory of gender dysphoria (referred to as rapid-onset gender dysphoria) that has not yet been clinically validated and the possibility of social influences and maladaptive coping mechanisms. Parent-child conflict may also explain some of the findings. More research that includes data collection from AYAs, parents, clinicians and third party informants is needed to further explore the roles of social influence, maladaptive coping mechanisms, parental approaches, and family dynamics in the development and duration of gender dysphoria in adolescents and young adults.

Introduction

In recent years, a number of parents have begun reporting in online discussion groups such as 4thwavenow in the US (<https://4thwavenow.com>) and Transgender Trend in the UK (<https://www.transgendertrend.com>) that their adolescent and young adult (AYA) children, who have had no histories of childhood gender identity issues, experienced a perceived sudden or rapid

onset of gender dysphoria. Parents have described clusters of gender dysphoria in pre-existing friend groups with multiple or even all members of a friend group becoming gender dysphoric and transgender-identified in a pattern that seems statistically unlikely based on previous research [1–8]. Parents describe a process of immersion in social media, such as “binge-watching” YouTube transition videos and excessive use of Tumblr, immediately preceding their child becoming gender dysphoric [1–2, 9]. These types of presentations have not been described in the research literature for gender dysphoria [1–10] and raise the question of whether social influences may be contributing to or even driving these occurrences of gender dysphoria in some populations of adolescents and young adults. (Note: The terminology of “natal sex”, including the terms “natal female” and “natal male”, will be used throughout this article. Natal sex refers to an individual’s sex as it was observed and documented at the time of birth. Some researchers also use the terminology “assigned at birth”).

Background

Gender dysphoria in adolescents

Gender dysphoria (GD) is defined as an individual’s persistent discomfort with their biological sex or assigned gender [11]. Two types of gender dysphoria studied include early-onset gender dysphoria, where the symptoms of gender dysphoria begin in early childhood, and late-onset gender dysphoria, where the symptoms begin after puberty [11]. Late-onset gender dysphoria that occurs during adolescence is now called adolescent-onset gender dysphoria. The majority of adolescents who present for care for gender dysphoria are individuals who experienced early-onset gender dysphoria that persisted or worsened with puberty although an atypical presentation has been described where adolescents who did not experience childhood symptoms present with new symptoms in adolescence [7, 12]. Adolescent-onset of gender dysphoria has only recently been reported in the literature for natal females [5, 10, 13–14]. In fact, prior to 2012, there were little to no research studies about adolescent females with gender dysphoria first beginning in adolescence [10]. Thus, far more is known about adolescents with early-onset gender dysphoria than adolescents with adolescent-onset gender dysphoria [6, 15]. Although not all research studies on gender dysphoric adolescents exclude those with adolescent-onset gender dysphoria [10], it is important to note that most of the studies on adolescents, particularly those about gender dysphoria persistence and desistance rates and outcomes for the use of puberty suppression, cross-sex hormones, and surgery only included subjects whose gender dysphoria began in childhood and subjects with adolescent-onset gender dysphoria would not have met inclusion criteria for these studies [16–24]. Therefore, most of the research on adolescents with gender dysphoria to date is not generalizable to adolescents experiencing adolescent-onset gender dysphoria [16–24] and the outcomes for individuals with adolescent-onset gender dysphoria, including persistence and desistance rates and outcomes for treatments, are currently unknown.

As recently as 2012, there were only two clinics (one in Canada and one in the Netherlands) that had gathered enough data to provide empirical information about the main issues for gender dysphoric adolescents [25]. Both institutions concluded that the management of adolescent-onset gender dysphoria is more complicated than the management of early-onset gender dysphoria and that individuals with adolescent-onset are more likely to have significant psychopathology [25]. The presentation of gender dysphoria can occur in the context of severe psychiatric disorders, developmental difficulties, or as part of large-scale identity issues and, for these patients, medical transition might not be advisable [13]. The APA Task Force on the Treatment of Gender Identity Disorder notes that adolescents with gender dysphoria “should be screened carefully to detect the emergence of the desire for sex reassignment in the context

of trauma as well as for any disorder (such as schizophrenia, mania, psychotic depression) that may produce gender confusion. When present, such psychopathology must be addressed and taken into account prior to assisting the adolescent's decision as to whether or not to pursue sex reassignment or actually assisting the adolescent with the gender transition." [25].

Demographic and clinical changes for gender dysphoria

Although, by 2013, there was research documenting that a significant number of natal males experienced gender dysphoria that began during or after puberty, there was little information about this type of presentation for natal females [5]. Starting in the mid-2000s there has been a substantial change in demographics of patients presenting for care with most notably an increase in adolescent females and an inversion of the sex ratio from one favoring natal males to one favoring natal females [26–28]. And now, some clinicians have noted that they are seeing increasingly in their clinic, the phenomenon of natal females expressing a post-puberty rapid onset of gender dysphoria [14]. Some researchers have suggested that increased visibility of transgender people in the media, availability of information online, with a partial reduction of stigma may explain some of the increases in numbers of patients seeking care [27], but these factors would not explain the reversal of the sex ratio, disproportionate increase in adolescent natal females, and the new phenomenon of natal females experiencing gender dysphoria that begins during or after puberty. If there were cultural changes that made it more acceptable for natal females to seek transition [27], that would not explain why the reversal of the sex ratio reported for adolescents has not been reported for older adult populations [26]. There are many unanswered questions about potential causes for the recent demographic and clinical changes for gender dysphoric individuals.

Social and peer influences

Parental reports (on social media) of friend clusters exhibiting signs of gender dysphoria [1–4] and increased exposure to social media/internet preceding a child's announcement of a transgender identity [1–2, 9] raise the possibility of social and peer influences. In developmental psychology research, impacts of peers and other social influences on an individual's development are sometimes described using the terms peer contagion and social contagion, respectively. The use of "contagion" in this context is distinct from the term's use in the study of infectious disease, and furthermore its use as an established academic concept throughout this article is not meant in any way to characterize the developmental process, outcome, or behavior as a disease or disease-like state, or to convey any value judgement. Social contagion [29] is the spread of affect or behaviors through a population. Peer contagion, in particular, is the process where an individual and peer mutually influence each other in a way that promotes emotions and behaviors that can potentially have negative effects on their development [30]. Peer contagion has been associated with depressive symptoms, disordered eating, aggression, bullying, and drug use [30–31]. Internalizing symptoms such as depression can be spread via the mechanisms of co-rumination, which entails the repetitive discussion of problems, excessive reassurance seeking (ERS), and negative feedback [30, 32–34]. Deviancy training, which was first described for rule breaking, delinquency, and aggression, is the process whereby attitudes and behaviors associated with problem behaviors are promoted with positive reinforcement by peers [35, 36].

Peer contagion has been shown to be a factor in several aspects of eating disorders. There are examples in the eating disorder and anorexia nervosa literature of how both internalizing symptoms and behaviors have been shared and spread via peer influences [37–41] which may have relevance to considerations of a rapid onset of gender dysphoria occurring in AYAs. Friendship cliques can set the norms for preoccupation with one's body, one's body image,

and techniques for weight loss, and can predict an individual's body image concerns and eating behaviors [37–39]. Peer influence is intensified in inpatient and outpatient treatment settings for patients with anorexia and counter-therapeutic subcultures that actively promote the beliefs and behaviors of anorexia nervosa have been observed [39–41]. In these settings, there is a group dynamic where the “best” anorexics (those who are thinnest, most resistant to gaining weight, and who have experienced the most medical complications from their disease) are admired, validated, and seen as authentic while the patients who want to recover from anorexia and cooperate with medical treatment are maligned, ridiculed, and marginalized [39–41]. Additionally, behaviors associated with deceiving parents and doctors about eating and weight loss, referred to as the “anorexic tricks,” are shared by patients in a manner akin to deviancy training [39–41]. Online environments provide ample opportunity for excessive reassurance seeking, co-rumination, positive and negative feedback, and deviancy training from peers who subscribe to unhealthy, self-harming behaviors. The pro-eating disorder sites provide motivation for extreme weight loss (sometimes calling the motivational content “thin-spiration”)[42–44]. Such sites promote validation of eating disorder as an identity, and offer “tips and tricks” for weight loss and for deceiving parents and doctors so that individuals may continue their weight-loss activities [42–44]. If similar mechanisms are at work in the context of gender dysphoria, this greatly complicates the evaluation and treatment of impacted AYAs.

In the past decade, there has been an increase in visibility, social media, and user-generated online content about transgender issues and transition [45], which may act as a double-edged sword. On the one hand, an increase in visibility has given a voice to individuals who would have been under-diagnosed and undertreated in the past [45]. On the other hand, it is plausible that online content may encourage vulnerable individuals to believe that nonspecific symptoms and vague feelings should be interpreted as gender dysphoria stemming from a transgender condition. Recently, leading international academic and clinical commentators have raised the question about the role of social media and online content in the development of gender dysphoria [46]. Concern has been raised that adolescents may come to believe that transition is the only solution to their individual situations, that exposure to internet content that is uncritically positive about transition may intensify these beliefs, and that those teens may pressure doctors for immediate medical treatment [25]. There are many examples on popular sites such as Reddit (www.reddit.com with subreddit ask/r/transgender) and Tumblr (www.tumblr.com) where online advice promotes the idea that nonspecific symptoms should be considered to be gender dysphoria, conveys an urgency to transition, and instructs individuals how to deceive parents, doctors, and therapists to obtain hormones quickly [47]. Fig 1 includes examples of online advice from Reddit and Tumblr.

Purpose

Rapid presentations of adolescent-onset gender dysphoria occurring in clusters of pre-existing friend groups are not consistent with current knowledge about gender dysphoria and have not been described in the scientific literature to date [1–8]. The purpose of this descriptive, exploratory research is to (1) collect data about parents' observations, experiences, and perspectives about their AYA children showing signs of a rapid onset of gender dysphoria that began during or after puberty, and (2) develop hypotheses about factors that may contribute to the onset and/or expression of gender dysphoria among this demographic group.

Materials and methods

The Icahn School of Medicine at Mount Sinai, Program for the Protection of Human Subjects provided approval of research for this project (HS#: 16–00744).

Instructions on lying	<ul style="list-style-type: none"> • “TL;DR find out what they want to hear if they’re gonna give you T and then tell them just that. It’s about getting treatment, not about being true to those around you. It’s not their business and a lot of time doctors will screw stuff up for you.”^a • “...Get a story ready in your head, and as suggested keep the lie to a minimum. And only for stuff that can’t be verified. Like how you were feeling, but was too afraid to tell anyone including your family.”^b • “I’d also look up the DSM for the diagnostic criteria for transgender and make sure your story fits it, assuming your psych follows it.”^c
Urgency to transition	<ul style="list-style-type: none"> • “...If you don’t do it when you are young. You’ll be miserable and unhappy with your body for the rest of your life.”^d
Vague and nonspecific symptoms called signs of GD	<ul style="list-style-type: none"> • “Signs of indirect gender dysphoria: 1. Continual difficulty with simply getting through the day. 2. A sense of misalignment, disconnect, or estrangement from your own emotions. 3. A feeling of just going through the motions in everyday life, as if you’re always reading from a script. 4. A seeming pointlessness to your life, and no sense of any real meaning or ultimate purpose. 5. Knowing you’re somehow different from everyone else, and wishing you could be normal like them...”^e
	<p>a. https://www.reddit.com/r/asktransgender/comments/2nt8gi/having_a_psych_eval_soon/#bottom-comments</p> <p>b. https://www.reddit.com/r/asktransgender/comments/4ag76/is_it_best_to_be_completely_honest_or_lie_a/</p> <p>c. https://www.reddit.com/r/asktransgender/comments/4ihwar/what_things_should_i_never_tell_my_psychologist/</p> <p>d. https://www.reddit.com/r/asktransgender/comments/3gpb94/at_the_final_stage_of_questioning_need_some/#bottom-comments</p> <p>e. https://transgenderteensurvivalguide.tumblr.com/post/62036014416/that-was-dysphoria-8-signs-and-symptoms-of</p>

Fig 1. Example quotes of online advice from Reddit and Tumblr.

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Participants

During the recruitment period, 256 parents completed online surveys that met the study criteria. The sample of parents included more women (91.7%) than men (8.3%) and participants were predominantly between the ages of 45 and 60 (66.1%) (Table 1). Most respondents were White (91.4%), non-Hispanic (99.2%), and lived in the United States (71.7%). Most respondents had a Bachelor’s degree (37.8%) or graduate degree (33.1%). The adolescents and young adults (AYAs) described by their parents were predominantly female sex at birth (82.8%) with an average current age of 16.4 years (range, 11–27 years). See Table 2.

Procedure

A 90-question survey instrument with multiple choice, Likert-type, and open-ended questions was created by the researcher. The survey was designed for parents (respondents) to complete about their adolescent and young adult children. The survey was uploaded onto Survey Monkey (SurveyMonkey, Palo Alto, CA, USA) via an account that was HIPPA-enabled. IRB approval for the study from the Icahn School of Medicine at Mount Sinai in New York, NY was received. Recruitment information with a link to the survey was placed on three websites where parents and professionals had been observed to describe what seemed to be a sudden or rapid onset of gender dysphoria (4thwavenow, transgender trend, and youthtranscriticalprofessionals), although the specific terminology “rapid onset gender dysphoria” did not appear on these websites until the recruitment information using that term was first posted on the sites. Website moderators and potential participants were encouraged to share the recruitment information and link to the survey with any individuals or communities that they thought might include eligible participants to expand the reach of the project through snowball sampling techniques. The survey was active from June 29, 2016 to October 12, 2016 (3.5 months)

Table 1. Demographic and other baseline characteristics of parent respondents.

Characteristics of Parent-respondents		n	%
Sex		254	
	Female	233	91.7
	Male	21	8.3
Age (y)		254	
	18–29	3	1.2
	30–44	74	29.1
	45–60	168	66.1
	>60	9	3.5
Race/Ethnicity*		255	
	White	233	91.4
	Other**	22	8.6
Country of Residence		254	
	US	182	71.7
	UK	39	15.4
	Canada	17	6.7
	Other	16	6.3
Education		254	
	Bachelor's degree	96	37.8
	Graduate degree	84	33.1
	Some college or Associates degree	63	24.8
	HS grad or GED	10	3.9
	<High School	1	0.4
Parent attitude on allowing gay and lesbian couples to marry legally		256	
	Favor	220	85.9
	Oppose	19	7.4
	Don't know	17	6.6
Parent belief that transgender people deserve the same rights and protections as others		255	
	Yes	225	88.2
	No	8	3.1
	Don't know	20	7.8
	Other	2	0.8

* may select more than one answer.

** declining order includes: Other, Multiracial, Asian, Hispanic.

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and took 30–60 minutes to complete. Participants completed the survey at a time and place of their own choosing. Data were collected anonymously and stored securely with Survey Monkey.

Participation in this study was voluntary and its purpose was clearly described in the recruitment information. Electronic consent was obtained. Participants had the option to withdraw consent at any time prior to submitting responses. Inclusion criteria were (1) completion of a survey with parental response that the child had a sudden or rapid onset of gender dysphoria; and (2) parental indication that the child's gender dysphoria began during or after puberty. There was logic embedded in the survey that disqualified surveys that answered “no” (or skipped the question) about whether the child had a sudden or rapid onset of gender dysphoria and 23 surveys were disqualified prior to completion (20 “no” answers and 3 skipped

Table 2. Demographic and other baseline characteristics of AYAs.

Characteristics of AYAs		n	%
AYA sex at birth (natal sex)		256	
	Female	212	82.8
	Male	44	17.2
AYA average current age (range of ages)	16.4 (11–27)	256	
Academic diagnoses		253	
	Gifted	120	47.4
	Learning Disability	11	4.3
	Both	27	10.7
	Neither	95	37.5
Natal female expressed sexual orientation before announcement*		212	
	Asexual	18	8.5
	Bisexual or Pansexual	78	36.8
	Gay or Lesbian	58	27.4
	Straight (Heterosexual)	75	35.4
	Did not express	57	26.9
Natal male expressed sexual orientation before announcement*		44	
	Asexual	4	9.1
	Bisexual or Pansexual	5	11.4
	Gay	5	11.4
	Straight (Heterosexual)	25	56.8
	Did not express	11	25.0
Gender dysphoria began		256	
	During puberty	125	48.8
	After puberty	131	51.2
Along with a rapid onset of GD, the AYA also:		256	
	Belonged to a friend group where one or multiple friends became transgender-identified during a similar timeframe	55	21.5
	Had an increase in social media/internet use	51	19.9
	Both of the above	116	45.3
	Neither	13	5.1
	Don't know	21	8.2

* may select more than one answer.

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answers). After cleaning the data for the 274 completed surveys, 8 surveys were excluded for not having a sudden or rapid onset of gender dysphoria and 10 surveys were excluded for not having gender dysphoria that began during or after puberty, which left 256 completed surveys for inclusion. As the survey was voluntary there was no refusal or dropout rate.

Recruitment sites

There were four sites known to post recruitment information about the research study. The first three were posted due to direct communication with the moderators of the sites. The fourth site posted recruitment information secondary to the snowball sampling technique. The following descriptions provide details about these sites.

4thwavenow

4thwavenow was created in 2015. The site, as seen in digitally archived screenshots from 2015 and 2016, stated that it is a “safe place for gender-skeptical parents and their allies”, offered support for parents, and expressed concern about the rush to diagnose young people as transgender and the rush to proceed to medical treatment for them [2, 48]. By June 2016, the site had expanded to include the writing of several parents, “formerly trans-identified people, and people with professional expertise and experience with young people questioning their gender identity” [9]. The perspective of this site might be described as cautious about medical and surgical transition overall—specifically with a cautious or negative view of medical and surgical interventions for children, adolescents, and young adults and an accepting view that mature adults can make their own decisions about transition [2, 9].

Transgendertrend

Transgendertrend was founded in November 2015. The digitally archived screenshots from November 2015 and July 2016 “Who Are We?” section include the following description, “We are an international group of parents based mainly in the UK, US and Canada, who are concerned about the current trend to diagnose ‘gender non-conforming’ children as transgender. We reject current conservative, reactionary, religious-fundamentalist views about sexuality. We come from diverse backgrounds, some with expertise in child development and psychology, some who were themselves extreme gender non-conforming children and adolescents, some whose own children have self-diagnosed as ‘trans’ and some who know supportive trans adults who are also questioning recent theories of ‘transgenderism’” [49]. In July of 2016, there was additional text added, expressing concern about legislation regarding public bathrooms and changing rooms [50].

Youth trans critical professionals

Youth Trans Critical Professionals was created in March 2016. The digitally archived screenshot from the April 2016 “About” section stated the following: “This website is a community of professionals “thinking critically about the youth transgender movement. We are psychologists, social workers, doctors, medical ethicists, and academics. We tend to be left-leaning, open-minded, and pro-gay rights. However, we are concerned about the current trend to quickly diagnose and affirm young people as transgender, often setting them down a path toward medical transition. Our concern is with medical transition for children and youth. We feel that unnecessary surgeries and/or hormonal treatments which have not been proven safe in the long-term represent significant risks for young people” [51].

Parents of transgender children

Parents of Transgender Children is a private Facebook group with more than 8,000 members [52]. The current “About” section states that requests to join the group “will be denied if you are not the parent (or immediate caregiver or family member) of a transgender, gender-fluid, gender-questioning, agender, or other gender-nonconforming child (of any age); or if you are uncooperative during screening” and that the “group is comprised of parents and parenting figures, as well as a select group of advocates INVITED by the admin[istrative] staff to assist & help us with understanding legal and other concerns” [52]. Although the parent discussions and comments are not viewable to non-members [52], this group is perceived to be pro -gender-affirming. The Parents of Transgender Children Facebook group is considered to be a site to find parents who are supportive of their child’s gender identity [53], and it is listed as a

resource in a gender affirming parenting guide [54] and by gender affirming organizations [55–56].

Measures

Basic demographic and baseline characteristics

Basic demographic and baseline characteristic questions, including parental attitudes about LGBT rights, were included. Parents were asked about their children’s mental health disorders and neurodevelopmental disabilities that were diagnosed before their child’s onset of gender dysphoria as well as during and after. The question, “Has your child been formally identified as academically gifted, learning disabled, both, neither?” was used as a proxy to estimate rates of academic giftedness and learning disabilities. Questions about trauma and non-suicidal self-injury were also included as were questions about social difficulties described in a previous research study about gender dysphoric adolescents [13].

DSM-5 diagnostic criteria for gender dysphoria in children

The DSM 5 criteria for gender dysphoria in children consist of eight indicators of gender dysphoria [57]. To meet criteria for diagnosis, a child must manifest at least six out of eight indicators including the one designated A1, “A strong desire to be the other gender or an insistence that one is the other gender (or some alternative gender different from one’s assigned gender).” Three of the indicators (A1, A7, and A8) refer to desires or dislikes of the child. Five of the indicators (A2–A6) are readily observable behaviors and preferences such as a strong preference or strong resistance to wearing certain kinds of clothing; a strong preference or strong rejection of specific toys, games and activities; and a strong preference for playmates of the other gender [57]. The eight indicators were simplified for language and parents were asked to note which, if any, their child had exhibited prior to puberty. The requirement of six-month duration of symptoms was not included.

DSM-5 diagnostic criteria for gender dysphoria in adolescents and adults

The DSM-5 criteria for gender dysphoria in adolescents and adults consist of six indicators of gender dysphoria [57]. To meet criteria for diagnosis, an adolescent or adult must manifest at least two of the six indicators. The six indicators were simplified for language, the first indicator was adjusted for a parent to answer about their child, and parents were asked to note which, if any, their child was expressing currently. The requirement of six-month duration of symptoms was not included.

Exposure to friend groups and social media/internet content

Survey questions were developed to describe AYA friend groups, including number of friends that became transgender-identified in a similar time period as the AYA, peer group dynamics and behaviors, and exposure to specific types of social media/internet content and messages that have been observed on sites popular with teens, such as Reddit and Tumblr.

Behaviors, outcomes, clinical interactions

Survey questions were developed to specifically quantify adolescent behaviors that had been described by parents in online discussions and observed elsewhere. Participants were asked to describe outcomes such as their child’s mental well-being and parent-child relationship since becoming transgender-identified. Parents were also asked about experiences with clinicians and their children’s disposition regarding steps taken for transition and duration of

transgender-identification both for children who were still transgender-identified and for children who were no longer transgender-identified.

Coping with strong or negative emotions

Two questions about the AYAs' ability to cope with negative and strong emotions were included. One question was "How does your child handle strong emotions? (please select the best answer)." Offered answers were "My child is overwhelmed by strong emotions and goes to great lengths to avoid feeling them," "My child is overwhelmed by strong emotions and tries to avoid feeling them," "My child neither avoids nor seeks out strong emotions," "My child tries to seek out situations in order to feel strong emotions," "My child goes to great lengths to seek out situations in order to feel strong emotions," "None of the above," "I don't know." The other question was "How would you rate your child's ability to deal with their negative emotions and channel them into something productive?" An example was given regarding dealing with a low test grade by studying harder for the next test (excellent) or by ignoring it, throwing a tantrum, blaming the teacher or distracting themselves with computer games, alcohol, drugs, etc. (extremely poor). Offered answers were: excellent, good, fair, poor, extremely poor, and I don't know.

Data analysis

Statistical analyses of quantitative data were performed using Excel and custom shell scripts (Unix). Quantitative findings are presented as frequencies, percentages, ranges, means and/or medians. ANOVAs, chi-squared, and t-tests comparisons were used where appropriate using publicly available calculators and $p < 0.05$ was considered significant. Qualitative data were obtained from open text answers to questions that allowed participants to provide additional information or comments. The types of comments and descriptions were categorized, tallied, and reported numerically. A grounded theory approach was selected as the analytic strategy of choice for handling the qualitative responses because it allowed the researcher to assemble the data in accordance with the salient points the respondents were making without forcing the data into a preconceived theoretical framework of the researcher's own choosing [58]. Illustrative respondent quotes and summaries from the qualitative data are used to illustrate the quantitative results and to provide relevant examples. Two questions were targeted for full qualitative analysis of themes (one question on friend group behaviors and one on clinician interactions). For these questions, a second reviewer with expertise in qualitative methods was engaged (MM). Both the author (LL) and reviewer (MM) independently analyzed the content of the open text answers and identified major themes. Discrepancies were resolved with collaborative discussion and themes were explored and refined until agreement was reached for the final lists of themes. Representative quotes for each theme were selected by LL, reviewed by MM, and agreement was reached.

Results

Baseline characteristics

Baseline characteristics (Table 1) included that the vast majority of parents favored gay and lesbian couples' right to legally marry (85.9%) and believed that transgender individuals deserve the same rights and protections as other individuals in their country (88.2%). Along with the sudden or rapid onset of gender dysphoria, the AYAs belonged to a friend group where one or multiple friends became gender dysphoric and came out as transgender during a similar time as they did (21.5%), exhibited an increase in their social media/internet use (19.9%), both

(45.3%), neither (5.1%), and don’t know (8.2%) (Table 2). For comparisons, the first three categories will be combined and called “social influence” (86.7%) and the last two combined as “no social influence” (13.3%). Nearly half (47.4%) of the AYAs had been formally diagnosed as academically gifted, 4.3% had a learning disability, 10.7% were both gifted and learning disabled, and 37.5% were neither. Sexual orientation as expressed by the AYA prior to transgender-identification is listed separately for natal females and for natal males (Table 2). Overall, 41% of the AYAs expressed a non-heterosexual sexual orientation prior to disclosing a transgender-identification.

It is important to note that none of the AYAs described in this study would have met diagnostic criteria for gender dysphoria in childhood (Table 3). In fact, the vast majority (80.4%) had zero indicators from the DSM-5 diagnostic criteria for childhood gender dysphoria with 12.2% possessing one indicator, 3.5% with two indicators, and 2.4% with three indicators. Breaking down these results, for readily observable indicators (A2-6), 83.5% of AYAs had zero indicators, 10.2% had one indicator, 3.9% had two indicators, and 1.2% had three indicators. For the desire/dislike indicators (A1, A7, A8), which a parent would have knowledge of if the child expressed them verbally, but might be unaware if a child did not, 95.7% had zero indicators and 3.5% had one indicator. Parents responded to the question about which, if any, of the indicators of the DSM criteria for adolescent and adult gender dysphoria their child was

Table 3. DSM 5 Indicators for gender dysphoria.

Characteristics		n	%
AYAs who would have met diagnostic criteria for gender dysphoria in childhood		0	0
Number of DSM 5 indicators for gender dysphoria in children exhibited prior to puberty		255	
	Zero indicators	205	80.4
	One indicator	31	12.2
	Two indicators	9	3.5
	Three indicators	6	2.4
	Four indicators	3	1.2
Desire/Dislike Indicators (A1, A7, or A8)		255	
	Zero indicators	244	95.7
	One indicators	9	3.5
	Two indicators	0	0
	Three indicators	1	0.4
Readily observable indicators (A2-A6)		254	
	Zero indicators	212	83.5
	One indicator	26	10.2
	Two indicators	10	3.9
	Three indicators	3	1.2
	Four indicators	3	1.2
Average number of DSM 5 indicators for adolescent and adult gender dysphoria that the AYA is experiencing currently (range)			
	3.5 (range 0–6)	247	
AYAs currently experiencing two or more indicators of gender dysphoria for adolescents and adults		250	
	Yes	208	83.2
	No	40	16.0
	Don’t know	2	0.8

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experiencing currently. The average number of positive current indicators was 3.5 (range 0–6) and 83.2% of the AYA sample was currently experiencing two or more indicators. Thus, while the focal AYAs did not experience childhood gender dysphoria, the majority of those who were the focus of this study were indeed gender dysphoric at the time of the survey completion.

The AYAs who were the focus of this study had many comorbidities and vulnerabilities pre-dating the onset of their gender dysphoria, including psychiatric disorders, neurodevelopmental disabilities, trauma, non-suicidal self-injury (NSSI), and difficulties coping with strong or negative emotions (Table 4). The majority (62.5%) of AYAs had one or more diagnoses of a psychiatric disorder or neurodevelopmental disability preceding the onset of gender dysphoria (range of the number of pre-existing diagnoses 0–7). Many (48.4%) had experienced a traumatic or stressful event prior to the onset of their gender dysphoria. Open text descriptions of trauma were categorized as “family” (including parental divorce, death of a parent, mental disorder in a sibling or parent), “sex or gender related” (such as rape, attempted rape, sexual harassment, abusive dating relationship, break-up), “social” (such as bullying, social isolation), “moving” (family relocation or change of schools); “psychiatric” (such as psychiatric hospitalization), and medical (such as serious illness or medical hospitalization). Almost half (45.0%) of AYAs were engaging in non-suicidal self-injury (NSSI) behavior before the onset of gender dysphoria. Coping styles for these AYAs included having a poor or extremely poor ability to handle negative emotions productively (58.0%) and being overwhelmed by strong emotions and trying to avoid (or go to great lengths to avoid) experiencing them (61.4%) (Table 4). The majority of respondents (69.4%) answered that their child had social anxiety during adolescence; 44.3% that their child had difficulty interacting with their peers, and 43.1% that their child had a history of being isolated (not associating with their peers outside of school activities).

Announcing a transgender-identification

At the time the AYA announced they were transgender-identified (“came out”), most were living at home with one or both parents (88.3%) and a small number were living at college (6.2%). The average age of announcement of a transgender-identification was 15.2 years of age (range 10–21) (Table 5). Most of the parents (80.9%) answered affirmatively that their child’s announcement of being transgender came “out of the blue without significant prior evidence of gender dysphoria.” Respondents were asked to pinpoint a time when their child seemed not at all gender dysphoric and to estimate the length of time between that point and their child’s announcement of a transgender-identity. Almost a third of respondents (32.4%) noted that their child did not seem gender dysphoric when they made their announcement and 26.0% said the length of time from not seeming gender dysphoric to announcing a transgender identity was between less than a week to three months. The most striking examples of “not seeming at all gender dysphoric” prior to making the announcement included a daughter who loved summers and seemed to love how she looked in a bikini, another daughter who happily wore bikinis and makeup, and another daughter who previously said, “I love my body!”

The majority of respondents (69.2%) believed that their child was using language that they found online when they “came out.” A total of 130 participants provided optional open text responses to this question, and responses fell into the following categories: why they thought the child was using language they found online (51); description of what the child said but didn’t provide a reason that they suspected the child was using language they found online (61); something else about the conversation (8) or the child (7) and don’t know (3). Of the 51 responses describing reasons why respondents thought their child was reproducing language

Table 4. AYA baseline comorbidities and vulnerabilities predating the onset of gender dysphoria.

Characteristics		n	%
Mental disorder or neurodevelopmental disability diagnosed prior to the onset of gender dysphoria*		251	
	Anxiety	117	46.6
	Depression	99	39.4
	Attention Deficit Hyperactivity Disorder (ADHD)	29	11.6
	Obsessive Compulsive Disorder (OCD)	21	8.4
	Autism Spectrum Disorder (ASD)	20	8.0
	Eating Disorder	12	4.8
	Bipolar Disorder	8	3.2
	Psychosis	6	2.4
	None of above	94	37.5
	(Other) Borderline	3	1.2
	(Other) Oppositional Defiant Disorder	2	0.8
Traumatic or stressful experience prior to the onset of gender dysphoria		252	
	Yes	122	48.4
	No	91	36.1
	Don't know	38	15.1
	Other	1	0.4
Types of trauma*		113	
	Family	50	44.2
	Sex/Gender related	34	30.1
	Social	23	20.4
	Moving	20	17.7
	Psychiatric	9	8.0
	Medical	7	6.2
Non-suicidal self-injury (NSSI) before the onset of gender dysphoria		180	
		81	45.0
Ability to handle negative emotions productively		255	
	Excellent/Good	34	13.3
	Fair	70	27.5
	Poor/Extremely Poor	148	58.0
	Don't know	3	1.2
Coping style for dealing with strong emotions		254	
	Overwhelmed by strong emotions and tries to /goes to great lengths to avoid feeling them	156	61.4
	Neither avoids nor seeks out strong emotions	29	11.4
	Tries to/goes to great lengths to seeks out strong emotions	33	13.0
	Don't know	25	9.8
	None of the above	11	4.3
Social vulnerabilities		255	
	During adolescence child had social anxiety	177	69.4
	Child had difficulty interacting with their peers	113	44.3
	History of being isolated (not interacting with peers outside of school activities)	110	43.1
	Child felt excluded by peers throughout most of grade school	93	36.5
	Child had persistent experiences of being bullied before the onset of gender dysphoria	74	29.0

*may select more than one answer.

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Table 5. Announcing a transgender-identification.

Characteristics		n	%
Age of AYA when the AYA announced a transgender-identification (range)	15.2 average (10–21)	255	
Living arrangement at announcement		256	
	Living at home with one or both parents	226	88.3
	Living at college or university	16	6.2
	Other	14	5.5
AYA's announcement came from "out of the blue, without significant prior evidence of gender dysphoria"		256	
	Yes	207	80.9
	No	33	12.9
	Other	16	6.2
If a time was pinpointed when the child seemed not at all gender dysphoric, how long between that time and the child's announcement of a transgender-identity?		250	
	Did not seem at all gender dysphoric when they announced and transgender-identity	81	32.4
	Less than a week to 3 months	65	26.0
	4–6 months	31	12.4
	7–9 months	10	4.0
	10–12 months	29	11.6
	More than 12 months	20	8.0
	Don't know	14	5.6
Parent suspects that when the child first announced a transgender-identity, that the child used language that they found online		253	
	Yes	175	69.2
	No	53	20.9
	N/A	25	9.9
Parent thinks their child is correct in their child's belief of being transgender		255	
	Yes	6	2.4
	No	195	76.5
	Don't know	38	14.9
	Other	16	6.3
How soon after the announcement did the AYA ask for transition?		255	
	At the same time	86	33.7
	Between less than one week to one month	33	12.9
	2–5 months after announcement	26	10.2
	6 or more months after announcement	19	7.5
	Other	16	6.3
	N/A	75	29.4
Intention and request for transition*		189	
	AYA told the parent that they want cross-sex hormones	127	67.2
	AYA told the parent that they want to go to a gender therapist/gender clinic	111	58.7
	AYA told the parent that they want surgery	101	53.4
	AYA brought up the issue of suicides in transgender teens as a reason that their parent should agree to treatment	59	31.2

(Continued)

Table 5. (Continued)

Characteristics		n	%
AYA has very high expectation that transitioning will solve their problems in social, academic, occupational, or mental health areas		256	
	Yes	143	55.9
	No	13	5.1
	Don't know	100	39.1
AYA was willing to work on basic mental health before seeking gender treatments		253	
	Yes	111	43.9
	No	71	28.1
	Don't know	30	11.9
	N/A	41	16.2

*may select more than one answer.

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they found online, the top two reasons were that it didn't sound like their child's voice (19 respondents) and that the parent later looked online and recognized the same words and phrases that their child used when they announced a transgender identity (14 respondents). The observation that it didn't sound like their child's voice was also expressed as "sounding scripted," like their child was "reading from a script," "wooden," "like a form letter," and that it didn't sound like their child's words. Parents described finding the words their child said to them "verbatim," "word for word," "practically copy and paste," and "identical" in online and other sources. The following quotes capture these top two observations. One parent said, "It seemed different from the way she usually talked—I remember thinking it was like hearing someone who had memorized a lot of definitions for a vocabulary test." Another respondent said, "The email [my child sent to me] read like all of the narratives posted online almost word for word."

The following case summaries were selected to illustrate peer, trauma, and psychiatric contexts that might indicate more complicated clinical pictures.

- A 12-year-old natal female was bullied specifically for going through early puberty and the responding parent wrote "as a result she said she felt fat and hated her breasts." She learned online that hating your breasts is a sign of being transgender. She edited her diary (by crossing out existing text and writing in new text) to make it appear that she has always felt that she is transgender.
- A 14-year-old natal female and three of her natal female friends were taking group lessons together with a very popular coach. The coach came out as transgender, and, within one year, all four students announced they were also transgender.
- A natal female was traumatized by a rape when she was 16 years of age. Before the rape, she was described as a happy girl; after the rape, she became withdrawn and fearful. Several months after the rape, she announced that she was transgender and told her parents that she needed to transition.
- A 21-year-old natal male who had been academically successful at a prestigious university seemed depressed for about six months. Since concluding that he was transgender, he went on to have a marked decline in his social functioning and has become increasingly angry and

hostile to his family. He refuses to move out or look for a job. His entire family, including several members who are very supportive of the transgender community, believe that he is “suffering from a mental disorder which has nothing to do with gender.”

- A 14-year-old natal female and three of her natal female friends are part of a larger friend group that spends much of their time talking about gender and sexuality. The three natal female friends all announced they were trans boys and chose similar masculine names. After spending time with these three friends, the 14-year-old natal female announced that she was also a trans boy.

The majority (76.5%) of the surveyed parents felt that their child was incorrect in their belief of being transgender (Table 5). More than a third (33.7%) of the AYAs asked for medical and/or surgical transition at the same time that they announced they were transgender-identified. Two thirds (67.2%) of the AYAs told their parent that they wanted to take cross-sex hormones; 58.7% that they wanted to see a gender therapist/gender clinic; and 53.4% that they wanted surgery for transition. Almost a third (31.2%) of AYAs brought up the issue of suicides in transgender teens as a reason that their parent should agree to treatment. More than half of the AYAs (55.9%) had very high expectations that transitioning would solve their problems in social, academic, occupational or mental health areas. While 43.9% of AYAs were willing to work on basic mental health before seeking gender treatments, a sizable minority (28.1%) were not willing to work on their basic mental health before seeking gender treatment. At least two parents relayed that their child discontinued psychiatric care and medications for pre-existing mental health conditions once they identified as transgender. One parent, in response to the question about if their child had very high expectations that transitioning would solve their problems elaborated, “Very much so. [She] discontinued anti-depressant quickly, stopped seeing psychiatrist, began seeing gender therapist, stopped healthy eating. [She] stated ‘none of it’ (minding what she ate and taking her Rx) ‘mattered anymore.’ This was her cure, in her opinion.”

Friend-group exposure

The adolescent and young adult children were, on average, 14.4 years old when their first friend became transgender-identified (Table 6). Within friendship groups, the average number of individuals who became transgender-identified was 3.5 per group. In 36.8% of the friend groups described, the majority of individuals in the group became transgender-identified. The order that the focal AYA “came out” compared to the rest of their friendship group was calculated from the 119 participants who provided the number of friends coming out both before and after their child and 74.8% of the AYAs were first, second or third of their group. Parents described intense group dynamics where friend groups praised and supported people who were transgender-identified and ridiculed and maligned non-transgender people. Where popularity status and activities were known, 60.7% of the AYAs experienced an increased popularity within their friend group when they announced a transgender-identification and 60.0% of the friend groups were known to mock people who were not transgender or LGBTIA (lesbian, gay, bisexual, transgender, intersex, or asexual).

For the question about popularity changes when the child came out as having a transgender-identification, 79 participants provided optional open text responses which were categorized as: descriptions of the responses the child received (39); descriptions of the friends (14); description that the child did not “come out” to friends (8); not sure (9); speculation on how the child felt from the response (4), other (5). Of the 39 descriptions of responses, 19 of these responses referred to positive benefits the child received after coming out including positive attention, compliments, increased status, increased popularity, increased numbers of online

Table 6. Friend group exposure.

Characteristics		n	%
The AYA has been part of a friend group where one or more friends has come out as transgender around a similar timeframe as they did		254	
	Yes	176	69.3
	No	47	18.5
	Don't know	31	12.2
Age of AYA when their first friend became transgender-identified (range)	14.4 average (11–21)	174	
Number of friends from the friendship group who became gender dysphoric average (range)	3.5 average (2–10)	138	
Where numbers known, friend groups where the MAJORITY of the friends in the friendship group became transgender-identified		125	
	Yes	46	36.8
	No	79	63.2
Order of the AYAs “coming out” compared to the others in the friendship group		119	
	First in the friendship group	4	3.4
	Second in the friendship group	52	43.7
	Third in the friendship group	33	27.7
	Fourth in the friendship group	18	15.1
	Fifth in the friendship group	5	4.2
	Sixth or Seventh in the friendship group	6	5.0
Where popularity status known, change in popularity within friend group when AYA announced their transgender-identification		178	
	Increased popularity	108	60.7
	Decreased popularity	11	6.2
	Unchanged popularity	59	33.1
Where friend group activities known, friend group known to mock people who are not transgender/LGBT		145	
	Yes	87	60.0
	No	58	40.0

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followers, and improved protection from ongoing bullying. The following are quotes from parents about the perceived benefits of transgender-identification afforded to their child. One respondent said, “Great increase in popularity among the student body at large. Being trans is a gold star in the eyes of other teens.” Another respondent explained, “not so much ‘popularity’ increasing as ‘status’. . .also she became untouchable in terms of bullying in school as teachers who ignored homophobic bullying . . .are now all at pains to be hot on the heels of any trans bullying.” Seven respondents described a mixed response where the child’s popularity increased with some friends and decreased with others. Seven respondents described a neutral response such as “All of the friends seemed extremely accepting.” Two described a temporary increase in their child’s popularity: “There was an immediate rush of support when he came out. Those same friends have dwindled to nothing as he rarely speaks to any of them now.” Another described the loss of friends. And two parents described that “coming out” prevented the loss of friends explained by one respondent as “to not be trans one would not have been included in his group.”

Several AYAs expressed significant concern about the potential repercussions from their friend group when they concluded that they were not transgender after all. There were two unrelated cases with similar trajectories where the AYAs spent some significant time in a different setting, away from their usual friend group, without access to the internet. Parents described that these AYAs made new friendships, became romantically involved with another person, and during their time away concluded that they were not transgender. In both cases, the adolescents, rather than face their school friends, asked to move and transfer to different high schools. One parent said that their child, "...couldn't face the stigma of going back to school and being branded as a fake or phony. ... Or worse, a traitor or some kind of betrayer. ... [and] asked us if we could move." In the other case, the parent relayed that their child thought none of the original friends would understand and expressed a strong desire to "...get out of the culture that 'if you are cis, then you are bad or oppressive or clueless.'" Both families were able to relocate and both respondents reported that their teens have thrived in their new environments and new schools. One respondent described that their child expressed relief that medical transition was never started and felt there would have been pressure to move forward had the family not moved away from the peer group.

Qualitative analysis

The open-ended responses from the question about whether the AYAs and friends mocked, teased, or made fun of individuals who weren't transgender or LGBTIA was selected for additional qualitative analysis. Seven major themes were identified from the comments provided by participants and are described, with representative supporting quotes.

Theme: Groups targeted. The groups targeted for mocking by the friend groups are often heterosexual (straight) people and non-transgender people (called "cis" or "cisgender"). Sometimes animosity was also directed towards males, white people, gay and lesbian (non-transgender) people, aromantic and asexual people, and "terfs". One participant explained, "They are constantly putting down straight, white people for being privileged, dumb and boring." Another participant elaborated, "In general, cis-gendered people are considered evil and unsupportive, regardless of their actual views on the topic. To be heterosexual, comfortable with the gender you were assigned at birth, and non-minority places you in the 'most evil' of categories with this group of friends. Statement of opinions by the evil cis-gendered population are consider phobic and discriminatory and are generally discounted as unenlightened."

Theme: Individuals targeted. In addition to targeting specific groups of people for mocking, the AYAs and their friend groups also directed mocking towards individuals in the AYAs' lives such as parents, grandparents, siblings, peers, allies, and teachers. The following quotes describe individuals targeted. One participant said, "They call kids who are not LGBT dumb and cis. And the mocking has been aimed at my transgender-identified child's [sibling]." Another parent said, "They definitely made fun of parents and teachers who did not agree with them." And a third participant said, "...they were asked to leave [a school-based LGBT club] because they were not queer enough [as straight and bisexual allies]. [One of them] was [then] bullied, harassed and denounced online."

Theme: Behaviors occurred both in person and in online settings. Parents observed the behaviors both in-person and in online settings, and specifically mentioned seeing posts and conversations on Tumblr, Twitter, Facebook, and Instagram. One participant said, "They speak with derision about how cis-gendered people do not understand them and are so close-minded." Another participant said, "I hear them disparaging heterosexuality, marriage and nuclear families." Another participant said, "On my daughter's Tumblr blog, she has liked or favorited or re-posted disparaging comments about those who aren't transgender or seem to

misunderstand the transgender identity.” And another parent reported, “Her real life friends don’t [mock non-LGBT people] but online they are always swapping jokes and comments about cisgender and about transphobia.”

Theme: Examples of behaviors. Participants gave many examples of the observed behaviors that were mocking towards non-transgender people and non-LGB people. One participant said, “My daughter called me a ‘breeder’ and says things in a mocking ‘straight person voice’. Her friends egg her on when she does this.” Another parent offered, “If they aren’t mocking ‘cis’ people, they are playing pronoun police and mocking people who can’t get the pronouns correct.” Another participant said, “New vocabulary includes ‘cis-stupid’ and ‘cis-stupidity.’” And a fourth participant described, “They assume anyone that is critical about being transgender (even just asking questions) is either ignorant or filled with hate.”

Theme: Emphasizing victimhood. Participants described that their children and friend group seemed to focus on feeling as though they were victims. One participant described, “They seem to wear any problems they may have, real or perceived like badges of honor. . . I feel like they want to believe they are oppressed & have really ‘been through life’, when they have little life experience.” Another participant said, “. . . there is a lot of feeling like a victim [and being] part of a victimized club.” Another parent said “But all talk is very ‘victim’ centered”. And finally, another said, “They passionately decry ‘Straight Privilege’ and ‘White Male Privilege’—while emphasizing their own ‘Victimhood.’”

Theme: Consequences of behaviors. A few participants describe that because of their child’s behavior, there were consequences, including making it difficult for one child to return to her school and the following description from another parent, “Most relatives have blocked her on [social media] over constant jokes regarding cis and straight people.”

Theme: Fueling the behaviors. In some cases, parents describe a synergistic effect of kids encouraging other kids to persist in the behavior as was described in a previous quote, “Her friends egg her on when she does this” as well as the following, “Lots of discussion revolving around how their teachers ‘discriminate’ or are ‘mean’ to them based on their declared LGBTIA identity, and they get each other riled up convincing each other of their persecution by these perceived wrongs . . . privately they mock our intolerance, and in person act upon these false beliefs by treating us as people out to get them. . .”

Internet/social media exposure

In the time period just before announcing that they were transgender, 63.5% of AYAs exhibited an increase in their internet/social media (Table 7). To assess AYA exposure to existing online content, parents were asked what kind of advice their child received from someone/people online. AYAs had received online advice including how to tell if they were transgender (54.2%); the reasons that they should transition right away (34.7%); that if their parents did not agree for them to take hormones that the parents were “abusive” and “transphobic” (34.3%); that if they waited to transition they would regret it (29.1%); what to say and what not to say to a doctor or therapist in order to convince them to provide hormones (22.3%); that if their parents were reluctant to take them for hormones that they should use the “suicide narrative” (telling the parents that there is a high rate of suicide in transgender teens) to convince them (20.7%); and that it is acceptable to lie or withhold information about one’s medical or psychological history from a doctor or therapist in order to get hormones/get hormones faster (17.5%). Two respondents, in answers to other questions, described that their children later told them what they learned from online discussion lists and sites. One parent reported, “He has told us recently that he was on a bunch of discussion lists and learned tips there. Places where teens and other trans people swap info. Like to use [certain, specific] words [with] the

Table 7. Internet/Social media exposures.

		n	%
AYAs internet/social media use just prior to announcement		255	
	Increased social media/internet use	162	63.5
	Decreased social media/internet use	3	1.2
	Unchanged social media/internet use	49	19.2
	Don't know	41	16.1
AYA exposure to internet content/advice*		251	
	How to tell if they are transgender	136	54.2
	The reasons that they should transition right away	87	34.7
	That if their parents did not agree to take them for hormones, that the parents are "abusive" and "transphobic"	86	34.3
	That if they waited to transition they would regret it	73	29.1
	That if they didn't transition immediately they would never be happy	72	28.7
	How to order physical items (binders, packers, etc) without parents finding out	67	26.7
	What to say and what NOT to say to a doctor or therapist in order to convince them to provide hormones	56	22.3
	That if their parents are reluctant to take them for hormones, that they should use the "suicide narrative" to convince them (telling the parents that there is a high rate of suicide in transgender teens.)	52	20.7
	Medical advice about the risks and benefits of hormones	55	21.9
	Medical advice about the risks and benefits of surgery	47	18.7
	That it is acceptable to lie to or withhold information about one's medical or psychological history from a doctor or therapist in order to get hormones/get hormones faster	44	17.5
	How to hide physical items from parents	40	15.9
	How to hide or make excuses for physical changes	26	10.4
	How to get money from others online in order to pay for medications, etc	25	10.0
	How to get hormones from online sources	24	9.6
	How to hide hormones from parents	21	8.4
	I don't know if my child received online advice about these topics	127	50.6

*may select more than one answer.

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therapist when describing your GD, because [they are] code for potentially suicidal and will get you a diagnosis and Rx for hormones." Another parent disclosed, "The threat of suicide was huge leverage. What do you say to that? It's hard to have a steady hand and say no to medical transition when the other option is dead kid. She learned things to say that would push our buttons and get what she wanted and she has told us now that she learned that from trans discussion sites."

Parents identified the sources they thought were most influential for their child becoming gender dysphoric. The most frequently answered influences were: YouTube transition videos (63.6%); Tumblr (61.7%); a group of friends they know in person (44.5%); a community/group of people that they met online (42.9%); a person they know in-person (not online) 41.7%. In contrast to the majority of responses, two participants commented that they didn't think the

sources influenced their child to become gender dysphoric, rather they gave their child a name for their feelings or gave the child confidence to come out. The following quotes illustrate the dominant quantitative findings. One parent wrote, “We believe the biggest influence was the online pro-transition blogs and youtube videos. We feel she was highly influenced by the ‘if you are even questioning your gender-you are probably transgender’ philosophy. . .In the ‘real world’ her friends, other trans peers, and newfound popularity were additional areas of reinforcement.” Another respondent described the online influence as part of a different question, “I believe my child experienced what many kids experience on the cusp of puberty—uncomfortableness!—but there was an online world at the ready to tell her that those very normal feelings meant she’s in the wrong body.”

Mental well-being, mental health, and behaviors

The trajectories of the AYAs were not consistent with the narrative of discovering one’s authentic self and then thriving. Specifically, parents reported that, after “coming out,” their children exhibited a worsening of their mental well-being. Additionally, parents noted worsening of the parent-child relationship and observed that their children had narrowed their interests (Table 8). Although small numbers of AYAs had improvement in mental well-being (12.6%), parent-child relationship (7.4%), grades/academic performance (6.4%), and had broadened their interests and hobbies (5.1%); the most common outcomes were worsened mental well-being (47.2%); worsened parent child relationship (57.3%); unchanged or mixed grades/academic performance (59.1%); and a narrowed range of interests and hobbies

Table 8. Outcomes and behaviors.

Characteristics		n	%
AYA mental well-being since announcement		254	
	Worse	120	47.2
	Better	32	12.6
	Unchanged or mixed	101	39.8
	Don’t know	1	0.4
Parent-child relationship since announcement		253	
	Worse	145	57.3
	Better	18	7.4
	Unchanged or mixed	89	35.2
	Don’t know	1	0.4
Grades/academic performance		220	
	Worse	76	34.5
	Better	14	6.4
	Unchanged/mixed	130	59.1
Range of interests and hobbies		255	
	Much broader	2	0.8
	Somewhat broader	11	4.3
	Unchanged	93	36.5
	Somewhat narrower	64	25.1
	Much narrower	56	22.0
	There are very few topics outside of transgender issues that my child is interested in	28	11.0
	Don/t know	1	0.4

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(58.1%). One parent describing her child’s trajectory offered, “After announcing she was trans-gender, my daughter’s depression increased significantly. She became more withdrawn. She stopped participating in activities which she previously enjoyed, stopped participating in fam-ily activities, and significantly decreased her interaction with friends. Her symptoms became so severe that she was placed on medication by her physician.” Table 9 describes cumulative rates of mental illness and neurodevelopmental disability at the time of survey.

A total of 63.8% of the parents have been called “transphobic” or “bigoted” by their children for one or more reasons, the most common being for: disagreeing with the child about the child’s self-assessment of being transgender (51.2%); recommending that the child take more time to figure out if their feelings of gender dysphoria persist or go away (44.6%); expressing concerns for the child’s future if they take hormones and/or have surgery (40.4%); calling their child by the pronouns they used to use (37.9%); telling the child they thought that hormones or surgery would not help them (37.5%); recommending that their child work on other mental health issues first to determine if they are the cause of the dysphoria (33.3%); calling the child by their birth name (33.3%); or recommending a comprehensive mental health evaluation before starting hormones and/or surgery (20.8%) (Table 10). There were eight cases of estrangement. Estrangement was child-initiated in six cases where the child ran away, moved out, or otherwise refused contact with parent. There were two cases where the estrangement was initiated by the parent because the AYA’s outbursts were affecting younger siblings or there was a threat of violence made by the AYA to the parent.

AYAs are reported to have exhibited one or more of the following behaviors: expressed dis-trust of information about gender dysphoria and transgenderism coming from mainstream doctors and psychologists (51.8%); tried to isolate themselves from their family (49.4%); expressed that they only trust information about gender dysphoria and transgenderism that comes from transgender websites and/or transgender people and sources (46.6%); lost interest in activities where participants aren’t predominantly transgender or LGBTIA (32.3%); stopped spending time with friends who were not transgender (25.1%); expressed distrust of people who were not transgender (22.7%) (Table 10). Many AYAs have also: withdrawn from their family (45.0%); told other people or posted on social media that their parent is “transphobic,” “abusive,” or “toxic” because the parent does not agree with child’s self-assessment of being transgender (43.0%); refused to speak to their parent (28.5%), defended the practice of lying to or withholding information from therapists or doctors in order to obtain hormones for transi-tion more quickly (16.5%); tried to run away (6.8%). The behaviors and outcomes listed above

Table 9. AYA Cumulative mental disorder and neurodevelopmental disability diagnoses.

Characteristics		n	%
Mental disorder or neurodevelopmental disability		243	
	Anxiety	154	63.4
	Depression	143	58.8
	Attention Deficit Hyperactivity Disorder (ADHD)	36	14.8
	Obsessive Compulsive Disorder (OCD)	30	12.3
	Autism Spectrum Disorder (ASD)	30	12.3
	Eating Disorder	17	7.0
	Bipolar Disorder	17	7.0
	Psychosis	8	3.3
	None of above	52	21.4
	(Other) Borderline	7	2.9
	(Other) Oppositional Defiant Disorder	2	0.8

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Table 10. Additional behaviors.

		n	%
Parents have been called “transphobic” or “bigoted” by their child for the following reasons*		240	
	Disagreeing with their child about the child’s assessment of being transgender	123	51.2
	Recommending that their child take more time to figure out if their feelings of gender dysphoria persist or go away	107	44.6
	Expressing concerns for their child’s future if the child were to take hormones and/or have surgery	97	40.4
	Referring to their child by the pronouns that they used to use before announcement	91	37.9
	Telling their child that they thought hormones/surgery would not help them	90	37.5
	Calling their child by the child’s birth name	80	33.3
	Recommending that their child work on other mental health issues first to determine if they are the cause of their dysphoria	80	33.3
	Recommending therapy for basic mental health issues (not related to gender)	74	30.8
	Recommending a comprehensive evaluation before starting hormones and/or surgery	50	20.8
	None of the above	87	36.2
Distrust and isolating behaviors exhibited by AYAs*		251	
	Expressed distrust of information about gender dysphoria and transgenderism coming from mainstream doctors and psychologists	130	51.8
	Tried to isolate themselves from their family	124	49.4
	Expressed that they ONLY trust information about gender dysphoria and transgenderism that comes from transgender websites and/or transgender people and sources	117	46.6
	Lost interest in activities where participants aren’t predominantly transgender or LGBTIA	81	32.3
	Lost interest in activities that were not related to transgender or LGBTIA issues	65	25.9
	Stopped spending time with friends who are not transgender	63	25.1
	Expressed distrust of people who are not transgender	57	22.7
	Expressed hostility towards people who are not transgender	46	18.3
	None of the above	44	17.5
Other behavior and outcomes for AYAs*		249	
	Withdrawn from family	112	45.0
	Told other people or posted on social media that their parent is “transphobic”, “abusive”, or “toxic” because the parent does not agree with the child’s assessment of being transgender	107	43.0
	Refused to speak to parent	71	28.5
	Defended the practice of lying to or withholding information from therapists or doctors in order to obtain hormones for transition more quickly	41	16.5
	Tried to run away	17	6.8
	Been unable to obtain a job	25	10.0
	Been unable to hold a job	18	7.2
	Dropped out of college	12	4.8
	Dropped out of high school	12	4.8
	Needed to take a leave of absence from college	12	4.8
	Been fired from a job	9	3.6
	Needed a leave of absence from high school	1	0.4
	None of the above	86	34.5
For any of the above, is this a significant change from the child’s baseline behavior?		161	
	Yes	115	71.4
	No	46	28.6

*may select more than one answer.

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were considered significant changes from the child's baseline behaviors for 71.4% of respondents checking any of the items.

There was a subset of eight cases where parents described watching their child have declining mental well-being as they became gender dysphoric and transgender-identified and then had improving mental well-being as they dropped or backed away from a transgender-identification. One parent described a marked change in her daughter when she was out of school temporarily. "[Her] routine was disrupted. She spent all day on the internet, and lost her many school friends—her only friends were on-line and members of the trans community. In three months, my daughter announced she is trans, gender dysphoric, wants binders and top surgery, testosterone shots. . . she started self-harming. Now back at school. . . she tweeted that she's so young, isn't sure if she is trans, no longer wants to be referred to by the male name she had chosen. . . Since she has started back at school and is being exposed to a wide variety of people she is WAY happier." Another parent described, "My daughter's insight has improved considerably over the last few years, and she has also outgrown the belief that she is transgender. My daughter actually seemed to be looking for a reason for her depression which is now being successfully treated. . . My daughter is MUCH happier now that she is being treated for her genuine issues. Coming out as trans made her much worse for a while."

There was a subset of 30 cases where the AYAs' transgender-identification occurred in the context of a decline in their ability to function (such as dropping out of high school or college, needing a leave of absence from high school or college, and/or being unable to obtain or hold a job), which parents reported as a significant change from their child's baseline behavior. The declines were substantial as 43.3% of these AYAs had been identified as academically gifted students (some described as top of their class in high school, earning outstanding grades at prestigious universities) before they began to fail their classes, drop out of high school or college, and became unable to hold a job. In most of these cases (76.7%), there was one or more psychiatric diagnosis made at the same time or within the year (60.0%) or within two years (16.7%) of the AYA's new transgender-identification. Of the 23 individuals who had a psychiatric diagnosis made within two years of assuming a transgender-identification, 91.3% (21/23) were diagnosed with depression; 73.9% (17/23) with anxiety; 26.0% (6/23) with bipolar disorder; 17.4% (4/23) with borderline personality disorder; 8.7% (2/23) with psychosis/psychotic episode; and 8.7% (2/23) with an eating disorder.

Clinical encounters

Parents were asked if their child had seen a gender therapist, gone to a gender clinic, or seen a physician for the purpose of beginning transition and 92 respondents (36.2%) answered in the affirmative (Table 11). Many of the respondents clarified that their child had seen a clinician regarding their gender dysphoria for evaluation only. Although participants were not asked directly what kind of provider their child saw, specialties that were mentioned in answers included: general psychologists, pediatricians, family doctors, social workers, gender therapists, and endocrinologists. For parents who knew the content of their child's evaluation, 71.6% reported that the clinician did not explore issues of mental health, previous trauma, or any alternative causes of gender dysphoria before proceeding and 70.0% report that the clinician did not request any medical records before proceeding. Despite all of the AYAs in this study sample having an atypical presentation of gender dysphoria (no gender dysphoria prior to puberty), 23.8% of the parents who knew the content of their child's visit reported that the child was offered prescriptions for puberty blockers and/or cross-sex hormones at the first visit.

One participant described, "For the most part, I was extremely frustrated with providers NOT acknowledging the mental disorder, anxiety, depression, etc before recommending

Table 11. Interactions with clinicians.

		n	%
Did the AYA see a gender therapist, go to a gender clinic or see a physician for the purpose of transition?		254	
	No	151	59.4
	Yes	92	36.2
	Don't know	11	4.3
Did the therapist/physician/clinic staff explore issues of mental health, previous trauma, or any alternative causes of gender dysphoria before proceeding?		100	
	Yes	21	21.0
	No	53	53.0
	Don't know	26	26.0
Did the therapist/physician/clinic staff request any medical records before proceeding?		99	
	Yes	21	21.2
	No	49	49.5
	Don't know	29	29.3
Of parents who knew the content of the visit, did the AYA receive an Rx for puberty blockers and/or cross-sex hormones at their first visit?		80	
	AYA received an Rx for puberty blockers and/or cross-sex hormones at their first visit	17	21.2
	AYA was offered a Rx for puberty blockers and/or cross-sex hormones at their first visit, but AYA or parent declined	2	2.5
	Total number of AYAs who received or were offered an Rx at first visit	19	23.8
	AYAs who did not receive/were not offered an Rx at their first visit	61	76.2
Did AYA misrepresent their history to the doctor or relay their history accurately?		96	
	Parent is reasonably sure or positive that their child misrepresented or omitted parts of their history	64	66.7
	Parent is reasonable sure or positive that their child relayed their history completely and accurately	12	12.5
	Don't know	20	20.8

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hormone replacement therapy.” And two participants described how the clinician treating their child’s gender dysphoria refused to speak with the patients’ primary care physicians. One participant said, “When we phoned the clinic, the doctor was hostile to us, told us to mind our own business. Our family doctor tried to reach our son’s new doctor, but the trans doctor refused to speak with her.” Another respondent shared “The pediatrician/‘gender specialist’ did not return calls or emails from the primary care physician who requested to talk with her about my son’s medical history before she saw and treated him. . .she disregarded all historical information provided by the family and primary care physician. . .did not verify any information provided by my. . .son at his first visit even after being provided with multiple other historical sources which differed significantly from his story.”

When asked about whether their child relayed their history completely and accurately to clinicians or whether they misrepresented or omitted parts of their history, of those who knew the content of their child’s visit, 84.2% of the parent respondents were reasonably sure or positive that their child had misrepresented or omitted parts of their history. Twenty-eight participants provided optional open text responses to this question and the responses were categorized into: describing how the parent knew that the child misrepresented their history

(5); the content of what the child misrepresented (6 misrepresenting in general, 4 misrepresenting to the clinician for a total of 10 examples); don't know/not sure (4); expressing certainty (1); and not relevant (8). For the five participants describing how they knew, the reasons included: being present when it happened, reading the report from the gender specialist, being told by their child that the child had misrepresented the truth, and being informed by the child's psychiatrist. One respondent shared, "I have read the report from the gender specialist and it omits all the relevant context painting an almost unrecognizable picture of my son." A second parent simply responded, "I was present." Another respondent relayed about their (natal male) child, "My daughter told me and her mother that the first therapist she saw asked her stereotypical questions. . . She was afraid that if she didn't describe herself as a 'typical girl' she would not be believed." And finally, one respondent wrote, "He has said now that he did [misrepresent his history] and used key words he was advised to say." Ten participants provided 13 examples of the content of misrepresentations and of these, 6 examples could have been easily verified to be false (claiming to be under the care of a psychiatrist, claiming to be on medication to treat a psychiatric condition, how one was doing academically, and claiming a childhood history of having playmates of one sex when the opposite was observed, and claiming strong childhood preferences for specific toys and clothing that is the opposite of what multiple individuals observed). Three of the content examples would have been challenging to verify as false including: how one was feeling as a child, how one was feeling when a picture was taken, and whether one was from an abusive home. And four of the content examples did not provide enough information to determine if they would be easy or challenging to verify as false, such as "My child distorts her history and our family life on a regular basis," and "He has created an entire narrative that just isn't true."

In addition to the previously mentioned case where the child literally rewrote her history by editing her diary, there were seven respondents who conveyed a process where their child was constantly rewriting their personal history to make it consistent with the idea that they always were transgender and/or had created a childhood history that was not what others had observed. It is unclear whether this process was deliberate or if the individuals were unaware of their actions. The following are quotes describing this phenomenon. One parent said, "...she is actively rewriting her personal history to support the idea that she was always trans." Another respondent added, "...my daughter denies events I recollect from her childhood and puberty that contradicts her narrative of 'always knowing she was a boy.'" Another respondent offered, "He is rewriting his personal history to suit his new narrative." And a fourth respondent described, "[Our] son has completely made up his childhood to include only girl friends and dressing up in girls clothes and playing with dolls, etc. This is not the same childhood we have seen as parents."

Qualitative analysis

The open-ended comments from the question about whether the clinician explored mental health, trauma or alternative causes of gender dysphoria before proceeding were selected for qualitative analysis. Nine major themes emerged from the data. Each theme is described in the following paragraphs with supporting quotes from participants.

Theme: Failure to explore mental health, trauma or alternative causes of GD. Parents described that clinicians failed to explore their child's mental health, trauma, or any alternative causes for the child's gender dysphoria. This failure to explore mental health and trauma occurred even when patients had a history of mental health disorder or trauma, were currently being treated for a mental health disorder, or were currently experiencing symptoms. One participant said, "Nothing other than gender dysphoria was considered to explain my daughter's

desire to transition.” Another participant said, “My daughter saw a child therapist and the therapist was preparing to support transgenering and did not explore the depression and anxiety or previous trauma.”

Theme: Insufficient evaluation. Another theme was insufficient evaluation where parents described evaluations that were too limited or too superficial to explore mental health, trauma or alternative causes of gender dysphoria. The following are three quotes by three different parents describing insufficient evaluations. One parent said, “The exploration was egregiously insufficient, very shallow, no effort to ask questions, engage in critical thinking about coexisting anxiety, or put on the brakes or even slow down.” Another participant stated, “When we tried to give our son’s trans doctor a medical history of our son, she refused to accept it. She said the half hour diagnosis in her office with him was sufficient, as she considers herself an expert in the field.” And a third parent wrote, “We were STUNNED by the lack of information, medical history sought by therapist and radical treatment suggestion. [One] visit. The idea is, ‘if they say they were born in the wrong body, they are. To question this will only hurt her and prolong her suffering.’ [Our] daughter has had trauma in [the] past. [She] never was asked about it. [The] therapist did not ask parents a single question about our daughter.”

Theme: Unwillingness or disinterest in exploring mental health, trauma or alternative causes of GD. Parents described that clinicians did not seem interested or willing to explore alternative causes. One parent described, “Her current therapist seems to accept her self diagnosis of gender dysphoria and follows what she says without seeming too much interested in exploring the sexual trauma in her past.” Another parent wrote, “The Asperger psychiatrist did not seem to care whether our daughter’s gender dysphoria stemmed from Asperger’s. If our daughter wanted to be male, then that was enough.” And a third parent said, “The therapist did ask about those issues but seemed to want to accept the idea wholeheartedly that my daughter was transgender first and foremost, all other factors aside.”

Theme: Mental health was explored. A few parents had the experience where the clinician either made an appropriate referral for further evaluation or the issues had been addressed previously. One parent said, “[The] previous mental health issues [were] already explored by other therapists ([my] child was in therapy and medicated before coming out as transgender).”

Theme: Failure to communicate with patients’ medical providers. Several participants described clinicians who were unwilling to communicate with primary care physicians and mental health professionals even those professionals who were currently treating the patient. One participant relayed, “She did not review the extensive psychiatric records that were available in a shared EMR [electronic medical record] and she did not consult with his outpatient psychiatrist prior to or after starting cross-sex hormonal therapy.” Another parent said, “My child had been seen for mental health issues for several years before presenting this new identity, but the endocrinologist did not consult the mental health professionals for their opinions before offering hormones.”

Theme: Misrepresentation of information by the patient. Several participants described how their child misrepresented their history to the clinician, thus, limiting the clinician’s ability to adequately explore mental health, trauma and alternative causes. One participant wrote, “At [the] first visit, [my] daughter’s dialogue was well-rehearsed, fabricated stories about her life told to get [the] outcome she desired. She parroted people from the internet.” Another parent reported, “My son concealed the trauma and mental health issues that he and the family had experienced.” And a third parent said, “I overheard my son boasting on the phone to his older brother that ‘the doc swallowed everything I said hook, line and sinker. Easiest thing I ever did.’”

Theme: Transition steps were pushed by the clinician. Some parents described clinicians who seemed to push the process of transition before the patient asked for it. One parent described that the doctor gave her daughter a prescription that she didn’t ask for, “The family

doctor who gave her the Androgel Rx [prescription] did NOT ask her many questions (she was surprised by this), nor did he await her assessment by a licensed psychiatrist before giving her this Rx. Nor did she ask him for this Rx.” Another parent reported that she and her child were at the endocrinologist’s office only to ask questions, and described, “. . . [he] didn’t listen to a word we were saying. He was too eager to get us set up with a ‘gender therapist’ to get the legal form he needed to start hormones, all while making sure we set up our next appointment within 6 months to start the hormones. . . .”

Theme: Parent views were discounted or ignored. Parents describe that the clinicians did not take their concerns seriously. One parent described, “I have to say I don’t know, but it is hard to believe that they adequately examined the history of bullying and being ostracized for being different, and the autistic traits that would lend a person like my son to risk everything for identifying with a group. I know that in the few contacts I had with the providers, my concerns were discounted.” And another said, “All of our emails went unanswered and were ignored. We are left out of everything because of our constant questioning of this being right for our daughter [because of her] trauma and current depression, anxiety and self-esteem problems.”

Theme: Parent had concerns about the clinicians’ competence, professionalism or experience. Parents expressed doubts about the clinicians regarding their experience, competence or professionalism. One parent said, “The clinic told me they explored these issues. I asked the risk manager at [redacted] if they’d considered a personality disorder. ‘Oh, no,’ she laughed. ‘That’s only with the older patients, not the teenagers.’ I’m deeply suspicious of their competence.” Another parent described, “What does concern me is that the people she talked to seemed to have no sense of professional duties, but only a mission to promote a specific social ideology.”

Steps towards transition and current identification status

This section reports on the duration of AYA transgender-identification (time from the AYA’s announcement of a transgender identity until the time the parent completed the survey) that covers, on average, 15.0 months (range 0.1–120 months) with a median of 11 months (Table 12). The steps taken towards transition during this timeframe are listed in Table 12. At the end of the timeframe, 83.2% of the AYAs were still transgender-identified, 5.5% were not still transgender-identified (desisted), 2.7% seemed to be backing away from transgender-identification, and 8.6% of the parents did not know if their child was still identifying as transgender. Descriptions of backing away or moving from transgender-identified to not transgender-identified include the following. One parent observed, “She identified as trans for six months . . . Now back at school, she is thinking maybe she’s not trans.” Another parent offered, “My daughter [identified] as trans from ages 13–16. She gradually desisted as she developed more insight into who she is.” One parent described that after one year of identifying as transgender, “basically, she changed her mind once she stopped spending time with that particular group of friends.” The duration of transgender-identification of the AYAs who were still transgender-identified at the time of survey was compared to the duration of those who were no longer transgender-identified and those who seemed to be backing away from a transgender-identification (combined) by t-test. The difference between these groups was statistically significant ($p = .025$), with a t-value of -2.25 showing that those who were no longer transgender-identified and backing away had a longer duration of identification (mean = 24.1 months) and those who were still transgender-identified had a shorter mean duration (mean = 14.4 months).

To explore the differences between the AYAs who had exposure to social influence (friend group, internet/social media, or both) and AYAs who did not have a clear exposure to social influence (neither and don’t know), a series of chi-squared calculations were performed for

Table 12. Transition steps and disposition.

		n	%
Transition Steps*		256	
	Changed hairstyle	216	84.4
	Changed style of clothing	210	82.0
	Asks to be called a new name	188	73.4
	Asks for different pronouns	175	68.4
	Taken cross-sex hormones	29	11.3
	Legally changed name on government documents	19	7.4
	Taken anti-androgens	11	4.3
	Taken puberty blockers	7	2.7
	Had surgery	5	2.0
	None of the above	14	5.5
Disposition		256	
	Still transgender-identified	213	83.2
	Not transgender-identified any more (desisted)	14	5.5
	Seems to be backing away from transgender-identification	7	2.7
	Parent doesn't know if the child is still transgender-identified	22	8.6
	De-transitioned (also counted in desisted category)	3	1.2
Duration of transgender-identification overall	Median duration 11 months, Mean duration 15.0 months (range 0.1 months-120 months), median 11 months	225	
Duration of transgender-identification if still transgender-identified	Median duration 11 months, mean duration 14.4 months, range (0.1 months-72 months)	204	
Duration of transgender-identification if no longer transgender-identified	Median duration 12 months, mean duration 24.2 months, range (.75 months to 120 months)	13	
Duration of transgender-identification if backing away	Median duration 12 months, mean duration 15 months, range (3 months-36 months)	8	

*may select more than one answer.

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selected variables. (See Table 13.) Statistically significant differences were revealed for AYAs with exposure to social influences having worse outcomes for mental well-being and parent-child relationships, and greater numbers exhibiting distrust, isolating and anti-social behaviors including: narrowed range of interests and hobbies, expressing that they only trusted information from transgender sources, trying to isolate themselves from their family, losing interest in activities that weren't predominantly with transgender or LGBTIA participants, and telling people or posting on social media that their parent is "transphobic," "abusive," or "toxic" because the parent doesn't agree with the child's assessment of being transgender. Although the differences in additional isolating and anti-social behaviors did not reach statistical significance, these behaviors trended towards higher rates in the AYAs who were exposed to social influence and may have not reached significant levels due to small numbers. No significant difference for age of AYA (at announcement or at time of survey completion) was detected between groups by a one-way ANOVA.

Discussion

This research describes parental reports about a sample of AYAs who would not have met diagnostic criteria for gender dysphoria during their childhood but developed signs of gender dysphoria during adolescence or young adulthood. The strongest support for considering that the gender dysphoria was new in adolescence or young adulthood is the parental answers for

Table 13. chi-squared comparisons for exposure to social influence (SI) vs not exposure to social influence (NSI).

		SI n (%)	NSI n (%)	p
Sex		222	34	.123
	Female	187 (84.2)	25 (73.5)	
	Male	35 (15.8)	9 (26.5)	
Indicators of childhood GD		221	33	.004
	0–2 indicators	216 (97.7)	29 (87.9)	
	3–4 indicators	5 (2.3)	4 (12.1)	
Currently have two or more GD indicators		214	34	.808
	Yes	179(83.6)	29 (85.3)	
	No	35(16.4)	5(14.7)	
No mental health or NDD diagnoses before onset of GD		222	34	.036
	Answered “None of the above”	87(39.9)	7 (20.6)	
Mental well-being since announcement		220	33	.001
	Worse	114 (51.8)	6 (18.2)	
	Better	24 (10.9)	8 (24.2)	
	Unchanged/Mixed	82 (37.3)	19 (57.6)	
Parent-child relationship since announcement		219	33	.006
	Worse	134 (61.2)	11 (33.3)	
	Better	13 (5.9)	5 (15.2)	
	Unchanged/Mixed	72 (32.9)	17 (51.5)	
Range of interests and hobbies		220	34	<0.001
	Broader range of interests and hobbies	10 (4.5)	3 (8.8)	
	Narrowed range of interest and hobbies	139 (63.2)	9 (26.5)	
	Unchanged range	71 (32.3)	22 (64.7)	
Distrust and Isolating Behaviors		222	34	
	Tried to isolate themselves from family	114(51.4)	10 (29.4)	.017
	Expressed that they ONLY trust information about GD and transgenderism that comes from transgender sources	107 (48.2)	10 (29.4)	.041
	Lost interest in activities where participants aren’t predominantly transgender or LGBTIA	76 (34.2)	5 (14.7)	.023
	Stopped spending time with non-transgender friends	59 (26.6)	4 (11.8)	.062
	Expressed distrust of people who are not transgender	52 (23.4)	5 (14.7)	.255
	Told people or posted on social media that their parent is “transphobic,” “abusive,” or “toxic” because the parent doesn’t agree with the child’s assessment of being transgender	102 (45.9)	5 (14.7)	<0.001
	Defended the practice of lying to or withholding information from doctors/therapists to get hormones for transition more quickly	38 (17.1)	3 (8.8)	.219
	Brought up the issue of suicide in transgender teens as a reason parents should agree to treatment	55 (24.8)	4 (11.8)	.093
Did the AYA misrepresent their history to the doctor or relay it accurately?		68	8	.075
	Parent is reasonable sure or positive that their child misrepresented or omitted parts of their history	59 (86.8)	5 (62.5)	
	Parent is reasonable sure or positive that child relayed their history completely and accurately	9 (13.2)	3 (37.5)	

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DSM 5 criteria for childhood gender dysphoria. Not only would none of the sample have met threshold criteria, the vast majority had zero indicators. Although one might argue that three of the indicators could plausibly be missed by a parent (A1, A7, and A8 if the child had not

expressed these verbally), five of the indicators (A2-6) are readily observable behaviors and preferences that would be difficult for a parent to miss. Six indicators (including A1) are required for a threshold diagnosis. The nonexistent and low numbers of readily observable indicators reported in the majority of this sample does not support a scenario in which gender dysphoria was always present but was only recently disclosed to the parents.

Parents reported that before the onset of their gender dysphoria, many of the AYAs had been diagnosed with at least one mental health disorder or neurodevelopmental disability and many had experienced a traumatic or stressful event. Experiencing a sex or gender related trauma was not uncommon, nor was experiencing a family stressor (such as parental divorce, death of a parent, or a mental health disorder in a sibling or parent). Additionally, nearly half were described as having engaged in self-harm prior to the onset of their gender dysphoria. In other words, many of the AYAs and their families had been navigating multiple challenges and stressors before gender dysphoria and transgender-identification became part of their lives. This context could possibly contribute to friction between parent and child and these complex, overlapping difficulties as well as experiences of same-sex attraction may also be influential in the development of a transgender identification for some of these AYAs. Care should be taken not to overstate or understate the context of pre-existing diagnoses or trauma in this population as they were absent in approximately one third and present in approximately two thirds of the sample.

This research sample of AYAs also differs from the general population in that it is predominantly natal female, white, and has an over-representation of individuals who are academically gifted, non-heterosexual, and are offspring of parents with high educational attainment [59–61]. The sex ratio favoring natal females is consistent with recent changes in the population of individuals seeking care for gender dysphoria. Gender clinics have reported substantial increases in referrals for adolescents with a change in the sex ratio of patients moving from predominantly natal males seeking care for gender dysphoria to predominantly natal females [26–28, 62]. Although increased visibility of transgender individuals in the media and availability of information online, with a partial reduction of stigma might explain some of the rise in the numbers of adolescents presenting for care [27], it would not directly explain why the inversion of the sex ratio has occurred for adolescents but not adults or why there is a new phenomenon of natal females experiencing late-onset and adolescent-onset gender dysphoria. The unexpectedly high rate of academically gifted AYAs may be related to the high educational attainment of the parents and may be a reflection of parents who are online, able to complete online surveys and are able to question and challenge current narratives about gender dysphoria and transition. There may be other unknown variables that render academically gifted AYAs susceptible to adolescent-onset and late-onset gender dysphoria. The higher than expected rate of non-heterosexual orientations of the AYAs (prior to announcement of a transgender-identity) may suggest that the desire to be the opposite sex could stem from experiencing homophobia as a recent study showed that being the recipient of homophobic name calling from one's peers was associated with a change in gender identity for adolescents [63]. The potential relationship of experienced homophobia and the development of a rapid onset of gender dysphoria during adolescence or young adulthood as perceived by parents deserves further study.

This sample is distinctively different than what is described in previous research about gender dysphoria because of the distribution of cases occurring in friendship groups with multiple individuals identifying as transgender, the preponderance of adolescent (natal) females, the absence of childhood gender dysphoria, and the perceived suddenness of onset. In this study, parental reports of transgender identification duration in AYAs suggest that in some cases (~8% in this study) gender dysphoria and transgender-identification may be temporary, and

that longer observation periods may be needed to assess such changes. Further research is needed to verify these results. There have been anecdotal reports of adolescents who desisted approximately 9–36 months after showing signs of a rapid onset of gender dysphoria, but longitudinal research following AYAs with gender dysphoria would be necessary to study desistance trends. Although it is still unknown whether transition in gender dysphoric individuals decreases, increases, or fails to change the rates of attempted or completed suicides [64], this study documents AYAs using a suicide narrative as part of their arguments to parents and doctors towards receiving support and transition services. Despite the possibility that the AYAs are using a suicide narrative to manipulate others, it is critical that any suicide threat, ideation or concern is taken seriously and the individual should be evaluated immediately by a mental health professional.

The majority of parents were reasonably sure or certain that their child misrepresented or omitted key parts of their history to their therapists and physicians. In some cases, the misrepresentation of one's history may simply be a deliberate act by a person who is convinced that transition is the only way that they will feel better and who may have been coached that lying is the only way to get what they think they need. For others, the misrepresentation may not be a conscious act. The creation of an alternate version of one's childhood that conforms to a story of always knowing one was transgender and that is in sharp contrast to the childhood that was observed by third parties raises the question of whether there has been the creation of false childhood memories as part of, or outside of, the therapy process. Respondent accounts of clinicians who ignored or disregarded information (such as mental health symptoms and diagnoses, medical and trauma histories) that did not support the conclusion that the patient was transgender, suggests the possibility of motivated reasoning and confirmatory biases on the part of clinicians. In the 1990s, the beliefs and practices of many mental health professionals may have contributed to their patients' creation of false childhood memories consistent with a child sexual abuse narrative and research since then has shown that false childhood memories of mundane events can be implanted in laboratory settings [65–67]. It may be worthwhile to explore if, in today's culture, there might be beliefs and practices of some mental health professionals that are contributing to their patients' creation of false childhood memories consistent with an "always knew/always were transgender" narrative.

Emerging hypotheses

Hypothesis 1: Social influences can contribute to the development of gender dysphoria

It is unlikely that friends and the internet can make people transgender. However, it is plausible that the following can be initiated, magnified, spread, and maintained via the mechanisms of social and peer contagion: (1) the *belief* that non-specific symptoms (including the symptoms associated with trauma, symptoms of psychiatric problems, and symptoms that are part of normal puberty) should be perceived as gender dysphoria and their presence as proof of being transgender; 2) the *belief* that the only path to happiness is transition; and 3) the *belief* that anyone who disagrees with the self-assessment of being transgender or the plan for transition is transphobic, abusive, and should be cut out of one's life. The spread of these beliefs could allow vulnerable AYAs to misinterpret their emotions, incorrectly believe themselves to be transgender and in need of transition, and then inappropriately reject all information that is contrary to these beliefs. In other words, "gender dysphoria" may be used as a catch-all explanation for any kind of distress, psychological pain, and discomfort that an AYA is feeling while transition is being promoted as a cure-all solution.

One of the most compelling findings supporting a potential role of social and peer contagion in the development or expression of a rapid onset of gender dysphoria is the clusters of transgender-identification occurring within friendship groups. The expected prevalence of transgender young adult individuals is 0.7% [8]. Yet, according to the parental reports, more than a third of the friendship groups described in this study had 50% or more of the AYAs in the group becoming transgender-identified in a similar time frame. This suggests a localized increase to more than 70 times the expected prevalence rate. This is an observation that demands urgent further investigation. One might argue that high rates of transgender-identified individuals within friend groups may be secondary to the process of friend selection: choosing transgender-identified friends deliberately rather than the result of group dynamics and observed coping styles contributing to multiple individuals, in a similar timeframe, starting to interpret their feelings as consistent with being transgender. More research will be needed to finely delineate the timing of friend group formation and the timing and pattern of each new declaration of transgender-identification. Although friend selection may play a role in these high percentages of transgender-identifying members in friend groups, the described pattern of multiple friends (and often the majority of the friends in the friend group) *becoming* transgender-identified in a similar timeframe suggests that there may be more than just friend selection behind these elevated percentages.

There are many insights from our understanding of peer contagion in eating disorders and anorexia that may apply to the potential role(s) of peer contagion in the development of gender dysphoria. Just as friendship cliques can set the level of preoccupation with one's body, body image, weight, and techniques for weight loss [37–39], so too may friendship cliques set a level of preoccupation with one's body, body image, gender, and the techniques to transition. The descriptions of pro-anorexia subculture group dynamics where the thinnest anorexics are admired while the anorexics who try to recover from anorexia are ridiculed and maligned as outsiders [39–41] resemble the group dynamics in friend groups that validate those who identify as transgender and mock those who do not. And the pro-eating-disorder websites and online communities providing inspiration for weight loss and sharing tricks to help individuals deceive parents and doctors [42–44] may be analogous to the inspirational YouTube transition videos and the shared online advice about manipulating parents and doctors to obtain hormones.

Hypothesis 2: Parental conflict might provide alternative explanations for selected findings

Parents reported subjective declines in their AYAs' mental health and in parent-child relationships after the children disclosed a transgender identification. Additionally, per parent report, almost half of the AYAs withdrew from family, 28.5% refused to speak to a parent, and 6.8% tried to run away. It is possible that some of these findings might be secondary to parent-child conflict. Parent-child conflict could arise from disagreement over the child's self-assessment of being transgender. It is also possible that some parents might have had difficulty coping or could have been coping poorly or maladaptively with their child's disclosure. Other potential explanations for the above findings include worsening of AYAs' pre-existing (or onset of new) psychiatric conditions or the use of maladaptive coping mechanisms. To further evaluate these possibilities, future studies should incorporate information about family dynamics, parent-child interactions, parent coping, child coping, and psychiatric trajectories. This study did not collect data about the parents' baseline coping styles, how they were coping with their child's disclosure, and whether their coping seemed to be maladaptive or adaptive. Nor did it explore parents' mental well-being. Future studies should explore these issues as well.

Although most parents reported an absence of childhood indicators for gender dysphoria, it is possible that these indicators might have existed for some of the AYAs and that some parents either failed to notice or ignored these indicators when they occurred. Because the readily observable indicators could also have been observed by other people in the child's life, future studies should include input from parents, AYAs and from third party informants such as teachers, pediatricians, mental health professionals, babysitters, and other family members to verify the presence or absence of readily observable behaviors and preferences during childhood. Parental approaches to their child's gender dysphoria might contribute to specific outcomes. This study did not specifically explore parental approaches to gender dysphoria or parental views on medical or surgical interventions. Additional studies that explore whether parents support or don't support: gender exploration; gender nonconformity; non-heterosexual sexual identities; mental health evaluation and treatment; and exploration of potential underlying causes for dysphoria would be extremely valuable. It would also be worthwhile to explore whether parents favor affirming the child as a person or affirming the child's gender identity and whether parents hold liberal, cautious, or negative views about the use of medical and surgical interventions for gender dysphoria in AYAs.

Hypothesis 3: Maladaptive coping mechanisms may underlie the development of gender dysphoria for some AYAs

For some individuals, the drive to transition may represent an ego-syntonic but maladaptive coping mechanism to avoid feeling strong or negative emotions similar to how the drive to extreme weight loss can serve as an ego-syntonic but maladaptive coping mechanism in anorexia nervosa [68–69]. A maladaptive coping mechanism is a response to a stressor that might relieve the symptoms temporarily but does not address the cause of the problem and may cause additional negative outcomes. Examples of maladaptive coping mechanisms include the use of alcohol, drugs, or self-harm to distract oneself from experiencing painful emotions. One reason that the treatment of anorexia nervosa is so challenging is that the drive for extreme weight loss and weight loss activities can become a maladaptive coping mechanism that allows the patient to avoid feeling and dealing with strong emotions [69–70]. In this context, dieting is not felt as distressing to the patient, because it is considered by the patient to be the solution to her problems, and not part of the problems. In other words, the dieting and weight loss activities are ego-syntonic to the patient. However, distress is felt by the patient when external actors (doctors, parents, hospital staff) try to interfere with her weight loss activities thus curtailing her maladaptive coping mechanism.

Findings that may support a maladaptive coping mechanism hypothesis include that the most likely description of AYA ability to use negative emotions productively was poor/ extremely poor and the majority of AYAs were described as “overwhelmed by strong emotions and tries to/goes to great lengths to avoid experiencing them.” Although these are not validated questions, the findings suggest, at least, that there is a history of difficulty dealing with emotions. The high frequency of parents reporting AYA expectations that transition would solve their problems coupled with the sizable minority who reported AYA unwillingness to work on basic mental health issues before seeking treatment support the concept that the drive to transition might be used to avoid dealing with mental health issues and aversive emotions. Additional support for this hypothesis is that the sample of AYAs described in this study are predominantly female, were described by parents as beginning to express symptoms during adolescence and contained an overrepresentation of academically gifted students which bears a strong resemblance to populations of individuals diagnosed with anorexia nervosa [71–75]. The risk factors, mechanisms and meanings of anorexia nervosa [69–70, 76] may ultimately

prove to be a valuable template to understand the risk factors, mechanisms, and meanings for some cases of gender dysphoria.

Transition as a drive to escape one's gender/sex, emotions, or difficult realities might also be considered when the drive to transition arises after a sex or gender-related trauma or within the context of significant psychiatric symptoms and decline in ability to function. Although trauma and psychiatric disorders are not specific for the development of gender dysphoria, these experiences may leave a person in psychological pain and in search of a coping mechanism. The first coping mechanism that a vulnerable person adopts may be the result of their environment and which narratives for pain and coping are most prevalent in that environment—in some settings a gender dysphoria/drive to transition may be the dominant paradigm, in some settings a body dysphoria/drive for extreme weight loss is dominant, and in another the use of alcohol and drugs to cope with pain may be dominant. Because maladaptive coping mechanisms do not address the root cause of distress and may cause their own negative consequences, an outcome commonly reported for this sample, AYAs experiencing a decline in their mental well-being after transgender-identification, is consistent with this hypothesis. There was a subset of AYAs for whom parents reported improvement in their mental well-being as they desisted from their transgender-identification which would not be inconsistent with moving from a maladaptive coping mechanism to an adaptive coping mechanism.

If the above hypotheses are correct, rapid onset of gender dysphoria that is socially mediated and/or used as a maladaptive coping mechanism may be harmful to AYAs in the following ways: (1) non-treatment or delayed treatment for trauma and mental health problems that might be the root of (or at least an inherent part of) the AYAs' issues; (2) alienation of the AYAs from their parents and other crucial social support systems; (3) isolation from mainstream, non-transgender society, which may curtail educational and vocational potential; and (4) the assumption of the medical and surgical risks of transition without benefit. In addition to these indirect harms, there is also the possibility that this type of gender dysphoria, with the subsequent drive to transition, may represent a form of intentional self-harm. Promoting the affirmation of a declared gender and recommending transition (social, medical, surgical) without evaluation may add to the harm for these individuals as it can reinforce the maladaptive coping mechanism, prolong the length of time before the AYA accepts treatment for trauma or mental health issues, and interfere with the development of healthy, adaptive coping mechanisms. It is especially critical to differentiate individuals who would benefit from transition from those who would be harmed by transition before proceeding with treatment.

Reflections

Clinicians need to be aware of the myriad of barriers that may stand in the way of making accurate diagnoses when an AYA presents with a desire to transition including: the developmental stage of adolescence; the presence of subcultures coaching AYAs to mislead their doctors; and the exclusion of parents from the evaluation. In this study, 22.3% of AYAs were reported as having been exposed to online advice about what to say to doctors to get hormones, and 17.5% to the advice that it is acceptable to lie to physicians; and the vast majority of parents were reasonably sure or positive that their child misrepresented their history to their doctor or therapist. Furthermore, although parents may be knowledgeable informants on matters of their own child's developmental, medical, social, behavioral, and mental health history- and quite possibly *because* they are knowledgeable- they are often excluded from the clinical discussion by the AYAs, themselves. An AYA telling their clinician that their parents are transphobic and abusive may indeed mean that the parents are transphobic and abusive. However, the findings of this research indicate that it is also possible that the AYA calls the parent

transphobic and abusive because the parent disagrees with the child's self-diagnosis, has expressed concern for the child's future, or has requested that the child be evaluated for mental health issues before proceeding with treatment.

The findings of this study suggest that clinicians need to be cautious before relying solely on self-report when AYAs seek social, medical or surgical transition. Adolescents and young adults are not trained medical professionals. When AYAs diagnose their own symptoms based on what they read on the internet and hear from their friends, it is quite possible for them to reach incorrect conclusions. It is the duty of the clinician, when seeing a new AYA patient seeking transition, to perform their own evaluation and differential diagnosis to determine if the patient is correct or incorrect in their self-assessment of their symptoms and their conviction that they would benefit from transition. This is not to say that the convictions of the patient should be dismissed or ignored, some may ultimately benefit from transition. However, careful clinical exploration should not be neglected, either. The patient's history being significantly different than their parents' account of the child's history should serve as a red flag that a more thorough evaluation is needed and that as much as possible about the patient's history should be verified by other sources. The findings that the majority of clinicians described in this study did not explore trauma or mental health disorders as possible causes of gender dysphoria or request medical records in patients with atypical presentations of gender dysphoria is alarming. The reported behavior of clinicians refusing to communicate with their patients' parents, primary care physicians, and psychiatrists betrays a resistance to triangulation of evidence which puts AYAs at considerable risk.

It is possible that some teens and young adults may have requested that their discussions with the clinicians addressing gender issues be kept confidential from their parents, as is their right (except for information that would put themselves or others at harm). However, maintaining confidentiality of the patient does not prevent the clinician from listening to the medical and social history of the patient provided by the parent. Nor does it prevent a clinician from accepting information provided by the patient's primary care physicians and psychiatrists. Because adolescents may not be reliable historians and may have limited awareness and insight about their own emotions and behaviors, the inclusion of information from multiple informants is often recommended when working with or evaluating minors. One would expect that if a patient refuses the inclusion of information from parents and physicians (prior and current), that the clinician would explore this with the patient and encourage them to reconsider. At the very least, if a patient asks that all information from parents and medical sources be disregarded, it should raise the suspicion that what the patient is presenting may be less than forthcoming and the clinician should proceed with caution.

The argument to surface from this study is not that the insider perspectives of AYAs presenting with signs of a rapid onset of gender dysphoria should be set aside by clinicians, but that the insights of parents are a pre-requisite for robust triangulation of evidence and fully informed diagnosis. All parents know their growing children are not always right, particularly in the almost universally tumultuous period of adolescence. Most parents have the awareness and humility to know that even as adults they are not always right themselves. When an AYA presents with signs of a rapid onset of gender dysphoria it is incumbent upon all professionals to fully respect the young person's insider perspective but also, in the interests of safe diagnosis and avoidance of clinical harm, to have the awareness and humility themselves to engage with parental perspectives and triangulate evidence in the interest of validity and reliability.

The strengths of this study include that it is the first empirical description of a specific phenomenon that has been observed by parents and clinicians [14] and that it explores parent observations of the psychosocial context of youth who have recently identified as transgender with a focus on vulnerabilities, co-morbidities, peer group interactions, and social media use.

Additionally, the qualitative analysis of responses about peer group dynamics provides a rich illustration of AYA intra-group and inter-group behaviors as observed and reported by parents. This research also provides a glimpse into parent perceptions of clinician interactions in the evaluation and treatment of AYAs with an adolescent-onset (or young adult-onset) of gender dysphoria symptoms.

The limitations of this study include that it is a descriptive study and thus has the known limitations inherent in all descriptive studies. This is not a prevalence study and does not attempt to evaluate the prevalence of gender dysphoria in adolescents and young adults who had not exhibited childhood symptoms. Likewise, this study's findings did not demonstrate the degree to which the onset of gender dysphoria symptoms may be socially mediated or associated with a maladaptive coping mechanism, although these hypotheses were discussed here. Gathering more data on the topics introduced is a key recommendation for further study. It is not uncommon for first, descriptive studies, especially when studying a population or phenomenon where the prevalence is unknown, to use targeted recruiting. To maximize the possibility of finding cases meeting eligibility criteria, recruitment is directed towards communities that are likely to have eligible participants. For example, in the first descriptive study about children who had been socially transitioned, the authors recruited potential subjects from gender expansive camps and gender conferences where parents who supported social transition for young children might be present and the authors did not seek out communities where parents might be less inclined to find social transition for young children appropriate [77]. In the same way, for the current study, recruitment was targeted primarily to sites where parents had described the phenomenon of a rapid onset of gender dysphoria because those might be communities where such cases could be found. The generalizability of the study must be carefully delineated based on the recruitment methods, and, like all first descriptive studies, additional studies will be needed to replicate the findings.

Three of the sites that posted recruitment information expressed cautious or negative views about medical and surgical interventions for gender dysphoric adolescents and young adults and cautious or negative views about categorizing gender dysphoric youth as transgender. One of the sites that posted recruitment information is perceived to be pro-gender-affirming. Hence, the populations viewing these websites might hold different views or beliefs from each other. And both populations may differ from a broader general population in their attitudes about transgender-identified individuals. This study did not explore specific participant views about medical and surgical interventions for gender dysphoric youth or whether participants support or don't support: exploration of gender identity, exploration of potential underlying causes for gender dysphoria, affirmation of children as valued individuals or affirmation of children's gender identity. Future studies should explore all these issues. This study cannot speak to those details about the participants.

Respondents were asked, "Do you believe that transgender people deserve the same rights and protections as others in your country?" which is a question that was adapted from a question used for a US national poll [78]. Although this question cannot elicit specific details about a persons' beliefs about medical interventions, beliefs about transgender identification, or their beliefs about their own child, it can be used to assess if the participants in this study are similar in their basic beliefs about the rights of transgender people to the participants in the US national poll. The majority (88.2%) of the study participants gave affirmative answers to the question which is consistent with the 89% affirmative response reported in a US national poll [78]. All self-reported results have the potential limitation of social desirability bias. However, comparing this self-report sample to the national self-report sample [78], the results show similar rates of support. Therefore, there is no evidence that the study sample is appreciably different in their support of the rights of transgender people than the general American population.

It is also important to note that recruitment was not limited to the websites where the information about the study was first posted. Snowball sampling was also used so that any person viewing the recruitment information was encouraged to share the information with any person or community where they thought there could be potentially eligible participants, thus substantially widening the reach of potential respondents. In follow up studies on this topic, an even wider variety of recruitment sources should be attempted.

Another limitation of this study is that it included only parental perspective. Ideally, data would be obtained from both the parent and the child and the absence of either perspective paints an incomplete account of events. Input from the youth would have yielded additional information. Further research that includes data collection from both parent and child is required to fully understand this condition. However, because this research has been produced in a climate where the input from parents is often neglected in the evaluation and treatment of gender dysphoric AYAs, this research supplies a valuable, previously missing piece to the jigsaw puzzle. If Hypothesis 3 is correct that for some AYAs gender dysphoria represents an ego-syntonic maladaptive coping mechanism, data from parents are especially important because affected AYAs may be so committed to the maladaptive coping mechanism that their ability to assess their own situation may be impaired. Furthermore, parents uniquely can provide details of their child's early development and the presence or absence of readily observable childhood indicators of gender dysphoria are especially relevant to the diagnosis. There are, however, obvious limitations to relying solely on parent report. It is possible that some of the participating parents may not have noticed symptoms of gender dysphoria before their AYA's disclosure of a transgender identity; could have been experiencing shock, grief, or difficulty coping from the disclosure; or even could have chosen to deny or obscure knowledge of long term gender dysphoria. Readers should hold this possibility in mind. Overall, the 200 plus responses appear to have been prepared carefully and were rich in detail, suggesting they were written in good faith and that parents were attentive observers of their children's lives. Although this research adds the necessary component of parent observation to our understanding of gender dysphoric adolescents and young adults, future study in this area should include both parent and child input.

This research does not imply that no AYAs who become transgender-identified during their adolescent or young adult years had earlier symptoms nor does it imply that no AYAs would ultimately benefit from transition. Rather, the findings suggest that *not all* AYAs presenting at these vulnerable ages are correct in their self-assessment of the cause of their symptoms and *some* AYAs may be employing a drive to transition as a maladaptive coping mechanism. It may be difficult to distinguish if an AYA's declining mental health is occurring due to the use of a maladaptive coping mechanism, due to the worsening of a pre-existing (or onset of a new) psychiatric condition, or due to conflict with parents. Clinicians should carefully explore these options and try to clarify areas of disagreement with confirmation from outside sources such as medical records, psychiatrists, psychologists, primary care physicians, and other third party informants where possible. Further study of maladaptive coping mechanisms, psychiatric conditions and family dynamics in the context of gender dysphoria and mental health would be an especially valuable contribution to better understand how to treat youth with gender dysphoria.

More research is needed to determine the incidence, prevalence, persistence and desistence rates, and the duration of gender dysphoria for adolescent-onset gender dysphoria and to examine whether rapid-onset gender dysphoria is a distinct and/or clinically valid subcategory of gender dysphoria. Adolescent-onset gender dysphoria is sufficiently different from early-onset of gender dysphoria that persists or worsens at puberty and therefore, the research results from early-onset gender dysphoria should not be considered generalizable to

adolescent-onset gender dysphoria. It is currently unknown whether the gender dysphorias of adolescent-onset gender dysphoria and of late-onset gender dysphoria occurring in young adults are transient, temporary or likely to be long-term. Without the knowledge of whether the gender dysphoria is likely to be temporary, extreme caution should be applied before considering the use of treatments that have permanent effects such as cross-sex hormones and surgery. Research needs to be done to determine if affirming a newly declared gender identity, social transition, puberty suppression and cross-sex hormones can cause an iatrogenic persistence of gender dysphoria in individuals who would have had their gender dysphoria resolve on its own and whether these interventions prolong the duration of time that an individual feels gender dysphoric before desisting. There is also a need to discover how to diagnose these conditions, how to treat the AYAs affected, and how best to support AYAs and their families. Additionally, analyses of online content for pro-transition sites and social media should be conducted in the same way that content analysis has been performed for pro-eating disorder websites and social media content [44]. Finally, further exploration is needed for potential contributors to recent demographic changes including the substantial increase in the number of adolescent natal females with gender dysphoria and the new phenomenon of natal females experiencing late-onset or adolescent-onset gender dysphoria.

Conclusion

Collecting data from parents in this descriptive exploratory study has provided valuable, detailed information that allows for the generation of hypotheses about potential factors contributing to the onset and expression of gender dysphoria among AYAs. Emerging hypotheses include the possibility of a potential new subcategory of gender dysphoria (referred to as rapid-onset gender dysphoria) that has not yet been clinically validated and the possibility of social influences and maladaptive coping mechanisms contributing to the development of gender dysphoria. Parent-child conflict may also contribute to the course of the dysphoria. More research that includes data collection from AYAs, parents, clinicians and third party informants is needed to further explore the roles of social influence, maladaptive coping mechanisms, parental approaches, and family dynamics in the development and duration of gender dysphoria in adolescents and young adults.

Supporting information

S1 Appendix. Survey instrument.
(PDF)

S2 Appendix. COREQ checklist.
(PDF)

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Individuals Treated for Gender Dysphoria with Medical and/or Surgical Transition Who Subsequently Detransitioned: A Survey of 100 Detransitioners

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Abstract

The study's purpose was to describe a population of individuals who experienced gender dysphoria, chose to undergo medical and/or surgical transition and then detransitioned by discontinuing medications, having surgery to reverse the effects of transition, or both. Recruitment information with a link to an anonymous survey was shared on social media, professional listservs, and via snowball sampling. Sixty-nine percent of the 100 participants were natal female and 31.0% were natal male. Reasons for detransitioning were varied and included: experiencing discrimination (23.0%); becoming more comfortable identifying as their natal sex (60.0%); having concerns about potential medical complications from transitioning (49.0%); and coming to the view that their gender dysphoria was caused by something specific such as trauma, abuse, or a mental health condition (38.0%). Homophobia or difficulty accepting themselves as lesbian, gay, or bisexual was expressed by 23.0% as a reason for transition and subsequent detransition. The majority (55.0%) felt that they did not receive an adequate evaluation from a doctor or mental health professional before starting transition and only 24.0% of respondents informed their clinicians that they had detransitioned. There are many different reasons and experiences leading to detransition. More research is needed to understand this population, determine the prevalence of detransition as an outcome of transition, meet the medical and psychological needs of this population, and better inform the process of evaluation and counseling prior to transition.

Keywords Gender dysphoria · Detransition · Transgender

Introduction

Detransition is the act of stopping or reversing a gender transition. The visibility of individuals who have detransitioned is new and may be rapidly growing. As recently as 2014, it was challenging for an individual who detransitioned to find another person who similarly detransitioned (Callahan, 2018). Between 2015 and 2017, a handful of blogs written by individual detransitioners started to appear online, private support groups for detransitioners formed, and interviews with detransitioners began to appear in news articles, magazines, and

blogs (Anonymous, 2017; 4thwavenow, 2016; Herzog, 2017; McCann, 2017). Although few YouTube videos about detransition existed prior to 2016, multiple detransitioners started to post videos documenting their experiences in 2016 and the numbers of these videos continues to increase.¹ In late 2017, the subreddit r/detrans (r/detrans, 2020) was revitalized and in four years has grown from 100 members to more than 21,000 members. A member poll of r/detrans conducted in 2019 estimated that approximately one-third of the members responding to the survey were desisters or detransitioners (r/detrans, 2019). The Pique Resilience Project, a group of four detransitioned or desisted young women, was founded in 2018 as a way to share the experiences of detransitioners with the public (Pique Resilience Project, 2019). In late 2019, the Detransition Advocacy Network, a nonprofit organization to “improve the well-being of detransitioned people everywhere” was launched (The

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¹ A search of the word “detransition” in YouTube can be filtered by date of upload. https://www.youtube.com/results?search_query=%22detransition%22&sp=CAI%253D22.

Detransition Advocacy Network, 2020) and the first formal, in-person conference for detransitioned people was held (Bridge, 2020). In the face of this massive change, clinicians have called for more research into the experiences of detransitioners (Butler & Hutchinson, 2020; Entwistle, 2021; Marchiano, 2020).

Although there were rare published reports about detransitioners prior to 2016, most of the published literature about detransition is recent (Callahan, 2018; D'Angelo, 2018; Djordjevic et al., 2016; Kuiper & Cohen-Kettenis, 1998; Levine, 2018; Marchiano, 2017; Pazos Guerra et al., 2020; Stella, 2016; Turban & Keuroghlian, 2018; Turban et al., 2021; Vandenbussche, 2021). The prevailing cultural narratives about detransition are that most individuals who detransition will retransition and that the reasons for detransition are discrimination, pressures from others, and nonbinary identification (Turban et al., 2021). However, case reports are shedding light on a broader and more complex range of experiences that include trauma, worsened mental health with transition, re-identification with natal sex, and difficulty separating sexual orientation from gender identity (D'Angelo, 2018; Levine, 2018; Pazos Guerra et al., 2020).² Detransitioners and desisters, in their own words, have provided additional depth to the discussion, describing that:

- (1) Trauma (including sexual trauma) and mental health conditions contributed to their transgender identification and transition (Callahan, 2018; Herzog, 2017; twitter.com/fmtdetransed & twitter.com/radfemjourney, 2019)
- (2) Their dysphoria and transition were due to homophobia and difficulty accepting themselves as homosexual (Bridge, 2020; Callahan, 2018; upperhandMARS, 2020)
- (3) Peers, social media, and online communities were influential in the development of transgender identification and desire to transition (Pique Resilience Project, 2019; Tracey, 2020; upperhandMARS, 2020)
- (4) Their dysphoria was rooted in misogyny (Herzog, 2017)

Two recently published convenience sample reports provide additional context about the topic of detransition. First, Turban

et al. (2021) analyzed data from the United States Trans Survey (USTS) (James et al., 2016). The USTS contains data from 27,715 transgender and gender diverse adults from the U.S. who were recruited through lesbian, gay, bisexual, transgender, queer (LGBTQ), and allied organization outreach. The USTS included the question, "Have you ever detransitioned? In other words, have you ever gone back to living as your sex assigned at birth, at least for a while?" with the multiple choice options of "yes," "no," and "I have never transitioned." For the 2,242 participants who answered "yes," Turban et al. analyzed the responses to the multiple choice question, "Why did you detransition? In other words, why did you go back to living as your sex assigned at birth? (Mark all that apply)." Although most of the offered answer options were about external pressures to detransition (pressure from spouse or partner, pressure from family, pressure from friends, pressure from employer, discrimination, etc.), participants could write in additional reasons that were not listed. Turban et al.'s sample included more natal males (55.1%) than natal females (44.9%). Roughly half (50.2%) had taken cross-sex hormones and 16.5% had obtained surgery. The findings revealed that most (82.5%) of the sample expressed at least one external factor for detransitioning and 15.9% expressed at least one internal factor (factors originating from self).

The second study by Vandenbussche (2021) recruited detransitioners from online communities of detransitioners and analyzed data for the participants who answered affirmatively to the question, "Did you transition medically and/or socially and then stopped?" The sample of 237 participants was predominantly natal female (92%), and from the U.S. (51%) and Europe (32%). Most (65%) had transitioned both medically and socially. Participants selected from multiple choice options to indicate why they detransitioned with options covering a range of experiences. Respondents also had the option to write in additional reasons. Frequently endorsed reasons for detransition included realizing that their gender dysphoria was related to other issues (70%); health concerns (62%); observing that transition did not help their dysphoria (50%); and that they found alternatives to deal with their dysphoria (45%). In contrast to Turban et al. (2021), external factors such as lack of support, financial concerns, and discrimination were less common (13%, 12%, and 10%, respectively). Many in the sample described that when they detransitioned they lost support or were ostracized from lesbian, gay, bisexual, and transgender (LGBT) communities, suggesting that many of the participants in Vandenbussche (2021) would not have been reached by the recruitment efforts of the USTS (James et al., 2016).

The objective of the current study was to describe a population of individuals who experienced gender dysphoria, chose to undergo medical and/or surgical transition and then detransitioned by discontinuing medications, having surgery to reverse the effects of transition, or both. In contrast to Turban et al. (2021) and Vandenbussche (2021), this study focused only on

² The debate about the terminologies used to describe an individual's sex (including "assigned sex at birth," "biological sex," "natal sex," "birth sex," "sex," etc.) is far from settled. Although some professionals have argued for the use of "assigned sex at birth," others argue that this terminology is misleading and not consistent with the events that occur at birth and prior to birth (Bouman et al., 2017; Byng et al., 2018; Dahlen, 2020; Griffin et al., 2020). Supporting the unsettled nature of the discussion, I received conflicting comments from the reviewers of this manuscript about my selection of natal sex terms—one reviewer asked that I justify my preference for natal sex over the other terminologies; another reviewer expressed support for my use of natal sex. I prefer to use "natal sex" and "birth sex" because they are accurate and objective. Further, I propose that "natal sex" and "birth sex" might be seen as reasonable, polite compromise terms between "biological sex" and "assigned sex at birth."

individuals who transitioned and detransitioned medically, surgically, or both. For the purpose of this study, medical transition refers to the use of puberty blockers, cross-sex hormones, or anti-androgens and surgical transition refers to any of a variety of surgical procedures (common surgical procedures include mastectomy, genital surgery, and breast augmentation). This study does not describe the population of individuals who undergo medical or surgical transition without issue nor is it designed to assess the prevalence of detransition as an outcome of transition. Instead, the goal was to identify detransition reasons and narratives in order to inform clinical care and future research.

Method

Participants and Procedure

During the recruitment period, 101 individuals who met the study criteria completed online surveys. Inclusion criteria were (1) completion of a survey via Survey Monkey; (2) answering that they had taken or had one or more of the following for the purpose of gender transition: cross-sex hormones, anti-androgens, puberty blockers, breast surgery, genital surgery, other surgery; and (3) answering that they had done any of the following for the purpose of detransitioning: stopped taking cross-sex hormones, stopped taking anti-androgens, stopped taking puberty blockers, had any surgery to reverse transition. One survey was excluded for nonsense answers leaving 100 surveys for analysis. The sample included more natal females (69.0%) than natal males (31.0%) with respondents who were predominantly White (90.0%), non-Hispanic (98.0%), resided in the U.S. (66.0%); had no religious affiliation (63.0%), and support the rights of gay and lesbian couples to marry legally (92.9%) (see Table 1). At the time of survey completion, the mean age of respondents was 29.2 years ($SD=9.1$) though natal females were significantly younger ($M=25.8$; $SD=5.0$) than natal males ($M=36.7$; $SD=11.4$), $t(98)=-6.56$, $p<.001$. Prior to transitioning, natal females were more likely to report an exclusively homosexual sexual orientation and natal males were more likely to report an exclusively heterosexual sexual orientation.

A 115-question survey instrument with multiple choice, Likert-type, and open-ended questions was created by the author and two individuals who had personally detransitioned. The author had met both detransitioners by way of introductions from colleagues. The author and both individuals who had detransitioned created questions for the survey, provided feedback, and revised the survey questions collaboratively with a focus on content, clarity, and relevance to a variety of transition and detransition experiences. The survey instrument included two questions that were adapted from an online survey of female detransitioners (Stella, 2016). Once completed, the

survey was uploaded onto Survey Monkey (SurveyMonkey, Palo Alto, CA) via an account that was HIPAA-enabled.

Recruitment information with a link to the survey was posted on blogs that covered detransition topics and shared in a private online detransition forum, in a closed detransition Facebook group, and on Tumblr, Twitter, and Reddit. Recruitment information was also shared on the professional listservs for the World Professional Association for Transgender Health, the American Psychological Association Section 44, and the SEXNET listserv (which is a listserv of sex researchers and clinicians) and the professionals on the listservs were asked to share recruitment information with anyone they knew who might be eligible. Efforts were made to reach out to communities with varied views about the use of medical and surgical transition and recruitment information stated that participation was sought from individuals regardless of whether their transition experiences were positive, negative or neutral. Potential participants were invited to share recruitment information with any potentially eligible person or community with potentially eligible people. The survey was active from December 15, 2016 to April 30, 2017 (4.5 months). The median time to complete a survey was 49 min; 50% of the surveys were completed between 32 and 71 min. There were no incentives offered for participating. Data were collected anonymously, without IP addresses, and stored securely with Survey Monkey.

Participation in this study was voluntary. Electronic consent was obtained from all participants in the following manner. The first page of the online survey informed respondents about the research purpose, potential risks and benefits, that participation was voluntary, and provided contact information for the researcher. Survey questions were only displayed if the participant clicked “agree” which indicated that they read the information, voluntarily agreed to participate and were at least 18 years of age.

Measures

Demographic and Baseline Characteristics

Information was collected about participant age, natal sex, race/ethnicity, country of residence, educational attainment, socioeconomic status, religion, attitudes about legal marriage for gay and lesbian couples, and where they first heard about the study. The term sexual orientation in this article is intended to refer to the natal sex of the participant and the natal sex of the individuals with whom they are sexually attracted. Participants were asked to select one or more labels for how they identified their sexual orientation prior to transition with options inclusive of participant sex (e.g., asexual female, bisexual female, heterosexual female, etc.). These responses were coded to be consistent with participant natal sex and were categorized into homosexual, heterosexual, bisexual, pansexual, asexual, and multiple. The multiple category included respondents who

Table 1 Demographic and baseline characteristics

	Natal female <i>N</i> (%) <i>N</i> = 69	Natal male <i>N</i> (%) <i>N</i> = 31
<i>Race/ethnicity*</i>		
White	62 (89.9%)	28 (90.3%)
Multiracial	6 (8.7%)	3 (9.7%)
Other	4 (5.8%)	0 (0%)
Asian	1 (1.4%)	1 (3.2%)
Hispanic	1 (1.4%)	1 (3.2%)
Black	0 (0%)	0 (0%)
<i>Country of residence</i>		
USA	46 (66.7%)	20 (64.5%)
UK	8 (11.6%)	1 (3.2%)
Canada	5 (7.2%)	4 (12.9%)
Australia	2 (2.9%)	2 (6.5%)
Other	8 (11.6%)	4 (12.9%)
<i>Education</i>		
Bachelor's or graduate degree	29 (42.0%)	18 (58.1%)
Associates degree	3 (4.3%)	1 (3.2%)
Some college but no degree	28 (40.6%)	9 (29.0%)
High school graduate or GED	8 (11.6%)	2 (6.5%)
< High school	1 (1.4%)	0 (0%)
Other	0 (0%)	1 (3.2%)
<i>Socioeconomic status compared to others in country of residence</i>		
Above average (somewhat or very much)	19 (27.5%)	12 (38.7%)
About average	20 (29.0%)	7 (22.6%)
Below average (somewhat or very much)	27 (39.1%)	12 (38.7%)
Prefer not to say	3 (4.3%)	0 (0%)
<i>Categorized sexual orientation (by natal sex) prior to transition^a</i>		
Homosexual	18 (26.1%)	2 (6.5%)
Heterosexual	6 (8.7%)	12 (38.7%)
Bisexual	15 (21.7%)	8 (25.8%)
Pansexual	4 (5.8%)	1 (3.2%)
Multiple	20 (29.0%)	5 (16.1%)
Asexual	6 (8.7%)	3 (9.7%)
<i>Religious affiliation</i>		
No religious affiliation	41 (59.4%)	22 (73.3%)
Liberal Christian	5 (7.2%)	3 (10.0%)
Liberal Jewish	5 (7.2%)	0 (0%)
Conservative Christian	1 (1.4%)	2 (6.7%)
Liberal Muslim	1 (1.4%)	0 (0%)
Conservative Jewish	0 (0%)	0 (0%)
Conservative Muslim	0 (0%)	0 (0%)
Other	16 (23.2%)	3 (10.0%)
<i>Legal marriage for gay and lesbian couples</i>		
Favor	65 (97.0%)	26 (83.9%)
Oppose	1 (1.5%)	5 (16.1%)
Don't know	1 (1.5%)	0 (0%)
<i>Source where participant first heard about study</i>		
Detransition blogs	26 (37.7%)	15 (48.4%)
Other social media	37 (53.6%)	11 (35.5%)
A person they know	3 (4.3%)	3 (9.7%)
Other	3 (4.3%)	2 (6.5%)

*May select more than one answer

^aNatal females were more likely to express an exclusively homosexual sexual orientation prior to transition ($\chi^2 = 5.15$. The *p*-value is .023). Natal males were more likely to express an exclusively heterosexual sexual

Table 1 (continued)

orientation prior to transition ($\chi^2 = 13.05$. The p value is $< .001$). Natal sex differences were not significant for individuals expressing pre-transition sexual orientations of bisexual, pansexual, multiple, and asexual. For bisexual sexual orientation, $\chi^2 = 0.20$. For pansexual sexual orientation, $\chi^2 = 0.29$. For multiple sexual orientations reported, $\chi^2 = 1.88$. For asexual sexual orientation, $\chi^2 = 0.02$

selected more than one response where responses indicated more than one pattern of sexual attraction (e.g., lesbian female and heterosexual female). Other questions about baseline characteristics included questions about diagnosed psychiatric disorders and neurodevelopmental disabilities, trauma, and non-suicidal self-injury (NSSI) before the onset of gender dysphoria.

Gender Dysphoria Onset and Typologies

Participants were asked how old they were when they first experienced gender dysphoria and whether this was during childhood, at the onset of puberty, during puberty, or later. Respondents were categorized as having early-onset gender dysphoria if they indicated that their gender dysphoria began “during childhood” and late-onset gender dysphoria if their gender dysphoria began “at the onset of puberty” or later. To evaluate typologies, participants were characterized by Blanchard’s (1985, 1989) typology as homosexual (if the sexual orientations listed prior to transition were exclusively homosexual) or non-homosexual which includes heterosexual, asexual, bisexual, pansexual, and multiple responses.

Transition

Participants were asked for their age and the year that they first sought care to transition, sources that encouraged them to believe that transition would be helpful to them, and whether they felt pressured to transition. The friendship group dynamics that were identified in previous work were assessed by asking respondents whether their friendship group mocked people who were not transgender, whether people in their pre-existing friend group transitioned before the participant decided to transition, and how participant popularity changed after announcing that they would transition (Littman, 2018). Questions were asked about participant experiences with clinicians, the social, medical, and surgical steps they took to transition, and the duration of time spent taking each medication.

Detransition

Participants were asked for their age and the year that they decided to detransition, how long they were transitioned before deciding to detransition, their reasons for wanting to detransition, what sources encouraged them to believe that detransition would be helpful to them, and whether they felt pressured to detransition. Participants were also asked which

social, medical, and surgical steps they took to detransition and whether they contacted the doctor or clinic that they used for their transition to tell them that they detransitioned.

Transition and Detransition Narratives

In this article, “narratives” denote participant interpretations of their experiences and rationales surrounding their decisions to transition and detransition. To associate each participant survey with a set of relevant narratives, the data were reviewed with horizontal (beginning to end) passes and vertical passes for selected questions (these questions are listed in the supplemental materials). Surveys were coded as belonging to zero or more of the following narrative categories: discrimination, nonbinary, retransition, trauma and mental health, internalized homophobia, social influence, and misogyny. Each narrative and the responses that were associated with them are detailed below. Example quotes were selected with care taken to avoid quoting a participant more than once per narrative. Narratives are ordered and reported with the more commonly accepted narratives first and the newer narratives next.

The *discrimination* narrative was defined as when someone detransitioned due to experiencing discrimination or external social pressures. The *nonbinary* narrative consisted of answering that their current identification was “nonbinary/genderqueer” or providing open-text responses that described aspects of discovering or maintaining a nonbinary identification. Although there were no questions in the survey specifically asking about retransition, the *retransition* narrative was identified if participants expressed that they had retransitioned or resumed transition in any of the open-text responses in the survey. The *gender dysphoria was caused by trauma or a mental health condition* narrative was identified by selection for the answers, “what I thought were feelings of being transgender were actually the result of trauma,” “what I thought were feelings of being transgender were actually the result of a mental health condition,” “I discovered that my gender dysphoria was caused by something specific (ex. trauma, abuse, mental health condition)” or open-text responses consistent with these reasons. The *internalized homophobia/difficulty accepting oneself as a lesbian female, gay male, or bisexual person* narrative consisted of descriptions that the respondents’ discomfort and distress about being lesbian, gay, or bisexual was related to their gender dysphoria, transition, or detransition, or that they assumed they were transgender because they did not yet understand themselves to be lesbian, gay or bisexual. The *social pressure to transition* narrative was identified with an affirmative

answer to whether they felt pressured to transition with an open-text response indicating that the pressure came from a person or group of people. The *misogyny* narrative was identified for natal female respondents with open-text responses using the word “misogyny” or expressing a hatred of femaleness.

Gender Identification at Start of Transition and at Survey Completion

Participants were asked how they identified their gender when they started their transition and at the time of survey completion. They were given options of female, male, nonbinary/genderqueer, trans man/FTM, trans woman/MTF, none of the above, and other. Responses were coded by natal sex and categorized as transgender, birth sex, nonbinary, and other. Answers that were combinations of the above categories were reported as combinations such as “birth sex and nonbinary.”

Self-Appraisal of Transition and Detransition

One question asked if participants believe they were helped and another if they were harmed by their transition with options of “very much,” “a little,” or “not at all.” These results were categorized into exclusively helped, exclusively harmed, and both helped and harmed. Participants were asked which of the following reflected their feelings about their transition: “I am glad that I transitioned,” “I wish I had never transitioned,” “Transitioning distracted me from what I should have been doing,” “Transition was a necessary part of my journey.” Participants were asked to rate their regret about their transition (“no regrets,” “mild regrets,” “strong regrets,” and “very strong regrets”) and were asked to indicate their satisfaction with their decisions to transition and detransition (“extremely satisfied,” “very satisfied,” “somewhat satisfied,” “somewhat dissatisfied,” “very dissatisfied,” and “extremely dissatisfied”). Satisfaction options were collapsed into “satisfied” and “dissatisfied.” In addition, participants were asked if they knew then what they know now, would they have chosen to transition.

Data Analysis

After data were cleaned, statistical analyses were performed using google sheets. Results are presented as frequencies, percentages, medians, means and standard deviations. *t* tests and chi-square tests were performed for selected variables and were considered significant for $p < .05$. Qualitative data were obtained from the open-text answers to questions that allowed participants to provide additional information. Selected open-text responses were categorized, tallied, and reported numerically. Salient respondent quotes and summaries from the qualitative data were selected to illustrate the quantitative results and to provide relevant examples.

Results

Before Transition

Mental health diagnoses and traumatic experiences before the onset of gender dysphoria. Table 2 shows data about psychiatric disorders, neurodevelopmental disabilities, NSSI, and trauma that were reported as occurring prior to the onset of gender dysphoria. Because these conditions and events occurred before participants began to feel gender dysphoric, they cannot be considered to be secondary to gender incongruence or transphobia.

Gender dysphoria onset and typology. Most participants (82.0%) were living with one or both parents when they first experienced gender dysphoria at a mean age of 11.2 years ($SD = 5.6$). The mean age of gender dysphoria onset was not statistically different between natal females ($M = 11.3$; $SD = 5.4$) and natal males ($M = 11.0$; $SD = 5.9$), $t(96) = 0.25$. By Blanchard typologies, 26.1% of natal females were exclusively homosexual and 73.9% non-homosexual while 6.5% of natal males were exclusively homosexual and 93.5% non-homosexual (Blanchard, 1985, 1989). Slightly more than half of the respondents (56.0%) experienced early-onset gender dysphoria and slightly less than half (44.0%) experienced late-onset gender dysphoria. Although late-onset gender dysphoria in natal females was largely absent from the scientific literature prior to 2012 (Steensma et al., 2013; Zucker & Bradley, 1995; Zucker et al., 2012a), 55.1% of the natal female participants reported that their gender dysphoria began with puberty or later. Because the information about the timing of gender dysphoria onset was obtained from participants reporting on their own experiences, it can be assumed that these cases were indeed late-onset rather than early-onset gender dysphoria that was concealed from parents and other people.

Transition reasons. Table 3 shows data about the reasons that individuals wanted to transition and the most frequently endorsed were: wanting to be perceived as the target gender (77.0%); believing that transitioning was their only option to feel better (71.0%); the sensation that their body felt wrong the way it was (71.0%), and not wanting to be associated with their natal sex (70.0%). Most participants believed that transitioning would eliminate (65.0%) or decrease (63.0%) their gender dysphoria and that with transitioning they would become their true selves (64.0%).

Sources of transition encouragement and friend group dynamics. Participants identified sources that encouraged them to believe transitioning would help them. Social media and online communities were the most frequently reported, including YouTube transition videos (48.0%), blogs (46.0%), Tumblr (45.0%), and online communities (43.0%) (see supplemental materials). Also common were people who the respondents knew offline such as therapists (37.0%); someone (28.0%) or a group of friends (27.0%) that they knew in-person. A subset of

Table 2 Mental health diagnoses and traumatic experiences prior to the onset of gender dysphoria

	Natal female <i>N</i> (%) <i>N</i> = 69	Natal male <i>N</i> (%) <i>N</i> = 31
<i>Diagnosed with a mental illness or neurodevelopmental disability</i> ^{*a}		
Depression	27 (39.1%)	5 (16.1%)
Anxiety	22 (31.9%)	5 (16.1%)
Attention deficit hyperactivity disorder (ADHD)	10 (14.5%)	2 (6.5%)
Post-traumatic stress disorder (PTSD)	10 (14.5%)	1 (3.2%)
Eating disorders	10 (14.5%)	0 (0%)
Autism spectrum disorders	9 (13.0%)	1 (3.2%)
Bipolar disorder	9 (13.0%)	0 (0%)
Obsessive compulsive disorder	6 (8.7%)	3 (9.7%)
Borderline personality disorder	5 (7.2%)	0 (0%)
Schizophrenia or other psychotic disorders	1 (1.4%)	0 (0%)
None of the above	28 (40.6%)	17 (54.8%)
Other	7 (10.1%)	2 (6.5%)
<i>Non-suicidal self-injury (NSSI)</i> ^b		
Engaged in NSSI before the onset of gender dysphoria	19 (27.5%)	5 (16.1%)
<i>Trauma</i> ^c		
Experienced a trauma less than one year before the start of gender dysphoria	33 (47.8%)	4 (12.9%)

*May select more than one answer

^aNatal sex difference for one or more pre-existing diagnoses (100-none of the above) was not significant [$\chi^2(1, 100)=1.76$]

^bNatal sex differences for NSSI before the onset of gender dysphoria was not significant ($\chi^2=1.52$)

^cExperiencing a trauma less than one year before the start of gender dysphoria was statistically different [$\chi^2(1, 100)=11.19, p<.001$] with natal females > natal males

Table 3 Transition reasons

	Natal female <i>N</i> (%) <i>N</i> = 69	Natal male <i>N</i> (%) <i>N</i> = 31
<i>Reasons for transition</i> [*]		
I wanted others to perceive me as the target gender	53 (76.8%)	24 (77.4%)
I thought transitioning was my only option to feel better	50 (72.5%)	21 (67.7%)
My body felt wrong to me the way it was	50 (72.5%)	21 (67.7%)
I didn't want to be associated with my natal sex/natal gender	51 (73.9%)	19 (61.3%)
It made me uncomfortable to be perceived romantically/sexually as a member of my natal sex/natal gender	49 (71.0%)	18 (58.1%)
I thought transitioning would eliminate my gender dysphoria	43 (62.3%)	22 (71.0%)
I felt I would become my true self	42 (60.9%)	22 (71.0%)
I identified with the target gender	40 (58.0%)	24 (77.4%)
I thought transitioning would lessen my gender dysphoria	45 (65.2%)	18 (58.1%)
I felt I would fit in better with the target gender	36 (56.5%)	20 (64.5%)
I felt I would be more socially acceptable as a member of the target gender	38 (55.1%)	11 (35.5%)
I felt I would be treated better if I was perceived as the target gender	35 (50.7%)	14 (45.2%)
I saw myself as a member of the target gender	31 (44.9%)	18 (58.1%)
I thought transitioning would reduce gender-related harassment or trauma I was experiencing	35 (50.7%)	5 (16.1%)
I had erotic reasons for wanting to transition	9 (13.0%)	12 (38.7%)
Other	9 (13.0%)	3 (9.7%)

*May select more than one answer

participants experienced the friendship group dynamics identified in previous work, including belonging to a friendship group that mocked people who were not transgender (22.2%), having one or more friend from the pre-existing friend group transition before the participant decided to transition (36.4%), and experiencing an increase in popularity after announcing plans to transition (19.6%) (Littman, 2018). Most did not have this experience (68.7%, 61.6%, and 62.9%, respectively).

Pressure to transition. More than a third of the participants (37.4%) felt pressured to transition. Natal sex differences in feeling pressured to transition were significant by chi-square test with natal females > natal males $\chi^2(1, 99) = 4.22, p = .04$. Twenty-eight participants provided open-text responses of which 24 described sources of pressure (17 described social pressures and 7 described sources that were not associated with other people). Clinicians, partners, friends, and society were named as sources that applied pressure to transition, as seen in the following quotes: “My gender therapist acted like it [transition] was a panacea for everything;” “[My] [d]octor pushed drugs and surgery at every visit;” “I was dating a trans woman and she framed our relationship in a way that was contingent on my being trans;” “A couple of later trans friends kept insisting that I needed to stop delaying things;” “[My] best friend told me repeatedly that it [transition] was best for me;” “The forums and communities and internet friends;” “By the whole of society telling me I was wrong as a lesbian;” and “Everyone says that if you feel like a different gender... then you just are that gender and you should transition.” Participants also felt pressure to transition that did not involve other people as illustrated by the following: “I felt pressured by my inability to function with dysphoria” and “Not by people. By my life circumstances.”

Experiences with clinicians. When participants first sought care for their gender dysphoria or desire to transition, more than half of the participants (53.0%) saw a psychiatrist or psychologist; about a third saw a primary care doctor (34.0%) or a counselor (including licensed clinician social worker, licensed professional counselor, or marriage and family therapist) (32.0%); and 17.0% saw an endocrinologist. For transition, 45.0% of participants went to a gender clinic (44.4% of those attending a gender clinic specified that the gender clinic used the informed consent model of care); 28.0% went to a private doctor’s office; 26.0% went to a group practice; and 13.0% went to a mental health clinic (see supplemental materials).

The majority (56.7%) of participants felt that the evaluation they received by a doctor or mental health professional prior to transition was not adequate and 65.3% reported that their clinicians did not evaluate whether their desire to transition was secondary to trauma or a mental health condition. Although 27.0% believed that the counseling and information they received prior to transition was accurate about benefits and risks, nearly half reported that the counseling was overly positive about the benefits of transition (46.0%) and not negative enough about the risks (26.0%). In contrast, only a small

minority found the counseling not positive enough about benefits (5.0%) or too negative about risks (6.0%) suggesting a bias toward encouraging transition.

Transition

Participants were on average 21.9 years old ($SD = 6.1$) when they sought medical care to transition with natal females seeking care at younger ages ($M = 20.0$; $SD = 4.2$) than natal males ($M = 26.0$; $SD = 7.5$), $t(97) = -5.07, p < .001$. Given that the majority of natal males were categorized as Blanchard typology non-homosexual, the finding that natal males sought medical care to transition at older ages than natal females is concordant with previous research (Blanchard et al., 1987). The average year for seeking care was more recent for natal females ($M = 2011$; $SD = 3.8$) than natal males ($M = 2007$; $SD = 6.9$), $t(96) = 2.78, p = .007$, and thus, there may have been differences in the care they received due to differences in the culture surrounding transition and the prevailing medical approaches to gender dysphoria for the time.

At the start of transitioning, nearly all (98.0%) of the participants identified as either transgender (80.0%), nonbinary (15.0%), or both transgender and nonbinary (3.0%). Participants identified which social, medical, and surgical steps they had taken to transition. Table 4 shows these steps, separated by natal sex where appropriate. Most respondents adopted new pronouns (91.0%) and names (88.0%), and the vast majority (97.1%) of natal females wore a binder. Most participants took cross-sex hormones (96.0%) and most natal males took anti-androgens (87.1%). The most frequent transition surgery was breast or chest surgery for natal females (33.3%). Genital surgery was less common (1.4% of natal females and 16.1% of natal males). Natal females took testosterone for a mean duration of 2.0 years ($SD = 1.6$). Natal males took estrogen for a mean duration of 5.1 years ($SD = 5.9$) and anti-androgens for 2.8 years ($SD = 2.6$). The minority of patients who took puberty blockers took them for a mean duration of less than a year ($M = 0.9$ years; $SD = 0.6$).

Detransition

Before deciding to detransition, participants remained transitioned for a mean duration of 3.9 years ($SD = 4.1$) with natal females remaining transitioned for a shorter period of time ($M = 3.2$ years; $SD = 2.7$) than natal males ($M = 5.4$ years; $SD = 6.1$), $t(96) = -2.40, p = .018$. When participants decided to detransition they were a mean age of 26.4 years old ($SD = 7.4$) though natal females were significantly younger ($M = 23.6$; $SD = 4.5$) than natal males ($M = 32.7$; $SD = 8.8$), $t(97) = -6.75, p < .001$. The mean calendar year when participants decided to detransition was 2014 ($M = 2014$; $SD = 3.3$), but the difference

Table 4 Steps taken for social, medical, and surgical transition

	<i>N</i> (%)
<i>Social transition*</i>	
Pronouns	91 (91.0%)
Different name	88 (88.0%)
Clothes/hair/makeup	90 (90.0%)
Legal name change	49 (49.0%)
Gender/sex changed on government documents	36 (36.0%)
Voice training	20 (20.0%)
<i>Natal female</i>	
Wore a binder	67 (97.1%)
<i>Medical transition*</i>	
Cross-sex hormones	96 (96.0%)
Puberty blockers	7 (7.0%)
<i>Natal male</i>	
Anti-androgens	27 (87.1%)
<i>Surgical transition*</i>	
Face/neck surgery	5 (5.0%)
<i>Natal female</i>	
Breast/chest surgery	23 (33.3%)
Genital surgery (to create a penis)	1 (1.4%)
<i>Natal male</i>	
Breast implants	5 (16.1%)
Genital surgery (to create a vagina)	5 (16.1%)

*May select more than one answer

between natal females and natal males was not significant ($M=2014$, $SD=3.3$; $M=2014$, $SD=3.5$), $t(95)=0.52$.

Respondents detransitioned for a variety of reasons and most (87.0%) selected more than one reason. The most frequently endorsed reason for detransitioning was that the respondent's personal definition of male and female changed and they became comfortable identifying with their natal sex (60.0%) (see Table 5). Other commonly endorsed reasons were concerns about potential medical complications (49.0%); transition did not improve their mental health (42.0%); dissatisfaction with the physical results of transition (40.0%); and discovering that something specific like trauma or a mental health condition caused their gender dysphoria (38.0%). External pressures to detransition such as experiencing discrimination (23.0%) or worrying about paying for treatments (17.0%) were less common.

Encouragement and pressure to detransition. Participants were asked to select sources that encouraged them to believe that detransitioning would help them. These included blogs (37.0%), Tumblr (35.0%), and YouTube detransition videos (23.0%) (see supplemental materials). At some point in their process, 23.2% felt pressured to detransition. There was no significant difference between natal females and natal males for feeling pressured to detransition, $\chi^2(1, 99) = 1.11$. Of the 21 open-text responses provided, 14 respondents expressed social pressure to detransition; three expressed internal pressure to detransition and four provided responses that were neither

Table 5 Reasons for detransitioning

	Natal female <i>N</i> (%) <i>N</i> =69	Natal male <i>N</i> (%) <i>N</i> =31
<i>Reasons for detransitioning*</i>		
My personal definition of female or male changed and I became more comfortable identifying as my natal sex	45 (65.2%)	15 (48.4%)
I was concerned about potential medical complications from transitioning	40 (58.0%)	9 (29.0%)
My mental health did not improve while transitioning	31 (44.9%)	11 (35.5%)
I was dissatisfied by the physical results of the transition/felt the change was too much	35 (50.7%)	5 (16.1%)
I discovered that my gender dysphoria was caused by something specific (ex, trauma, abuse, mental health condition)	28 (40.6%)	10 (32.3%)
My mental health was worse while transitioning	27 (39.1%)	9 (29.0%)
I was dissatisfied by the physical results of the transition/felt the change was not enough	22 (31.9%)	11 (35.5%)
I found more effective ways to help my gender dysphoria	25 (36.2%)	7 (22.6%)
My physical health was worse while transitioning	21 (30.4%)	11 (35.5%)
I felt discriminated against	12 (17.4%)	11 (35.5%)
I had medical complications from transitioning	12 (17.4%)	7 (22.6%)
Financial concerns about paying for transition care	11 (15.9%)	6 (19.4%)
My gender dysphoria resolved	10 (14.5%)	5 (16.1%)
My physical health did not improve while transitioning	9 (13.0%)	2 (6.5%)
I resolved the specific issue that was the cause of my gender dysphoria	6 (8.7%)	4 (12.9%)
I realized that my desire to transition was erotically motivated	1 (1.4%)	5 (16.1%)
Other	19 (27.5%)	6 (19.4%)

*May select more than one answer

or unclear. Regarding social pressure to detransition, seven participants expressed that the pressure came from partners, parents, or other family members as shown in the following example quotes: “I was threatened that if I did not immediately detransition I would NEVER see my [...] children again,” “My father very much wanted me to desist,” and “Parents constantly encouraging me to detransition.” Five participants expressed societal pressure to detransition as expressed in the following quotes: “I did not pass, I was mocked in public, I could not get a job. It was not ok to be trans” and “Well, I mean basically the entire world was against me transitioning, so yeah.” One participant felt pressured by doctors and another one from a blog.

Detransition steps. Table 6 shows data about the social, medical, and surgical steps participants took to detransition. Nearly all participants medically detransitioned by ceasing cross-sex hormones (95.0%). Social detransition steps were also common and included returning to the use of previously used pronouns (63.0%) and birth names (33.0%) and changing one’s clothes and hair presentations (48.0%). Surgical detransition steps were less common (9.0%).

Finding better ways of coping with gender dysphoria. Participants were asked to select responses that they considered to have been better ways for them to cope with their gender dysphoria. Responses included community (44.0%), mindfulness/meditation (41.0%), exercise (39.0%), therapy (24.0%), trauma work (24.0%), medication to treat a mental health condition (18.0%), and yoga (14.0%).

Transition and Detransition Narratives

Several transition and detransition narratives emerged from the data. A sizable minority of participants (41.0%) expressed more than one narrative in their responses.

The *discrimination and external pressures to detransition* narrative was described by 29.0% of participants. Examples include: “I had to detransition in order to get a job”; “I was afraid of being homeless and unable to support myself”; “I felt much happier with myself but I couldn’t go anywhere without being afraid. I passed okay but not perfectly. I was stared down and sneered at in the women’s clothes section, I wouldn’t dare use a public toilet because I’d find either violent men or women who wished an encounter with a violent man on me.”

A *nonbinary* narrative was expressed by 16.0% of participants. Some described that they discovered their nonbinary gender identity during their transition, as in the following quotes: “I still was uncomfortable with my body and figured I should stop and make sure I really wanted to keep going. I didn’t and I decided I must be nonbinary, not FTM”; “Transitioning didn’t do what I thought I wanted it to. I had transitioned to the wrong gender. I still felt wrong. Then, I realized I was not male, but genderqueer. I detransitioned to suit my true identity.” And others described a consistent nonbinary identification, as in the following quote, “I identified the same way that I did before.

Table 6 Social, medical, and surgical detransition steps

	N (%)
<i>Social detransition*</i>	
Previous pronouns	63 (63.0%)
Clothes/hair/makeup	48 (48.0%)
Birth name	33 (33.0%)
New name (not birth name)	24 (24.0%)
None of the above	2 (2.0%)
<i>Medical detransition*</i>	
Stopped cross-sex hormones	95 (95.0%)
Stopped puberty blockers	4 (4.0%)
Started hormones consistent with natal sex	14 (14.0%)
Natal male	
Stopped anti-androgens	17 (54.8%)
<i>Surgical detransition*</i>	
Surgery to reverse changes from transition	9 (9.0%)

*May select more than one answer

I had gotten what I wanted out of HRT and was ready to stop taking it.” (Cross-sex hormones are sometimes referred to as “hormone replacement therapy” and abbreviated as HRT).

Three participants (3.0%) expressed the *retransition* narrative in open-text answers indicating that they had retransitioned, including the following quotes: “I am now transitioning for a second time”; I retransitioned after 5 years of detransitioning”; and “Anyway, I retransitioned over 10 years after detransitioning.”

Most participants (58.0%) expressed the *gender dysphoria was caused by trauma or a mental health condition* narrative which included endorsing the response options indicating that their gender dysphoria was caused by something specific, such as a trauma or a mental health condition. More than half of the participants (51.2%) responded that they believe that the process of transitioning delayed or prevented them from dealing with or being treated for trauma or a mental health condition. The following are example quotes that were in response to why participants chose to detransition: “I slowly began addressing the mental health conditions and traumatic experiences that caused such a severe disconnect between myself and my body...”; “I was starting to become critical of transition because I felt that many people were doing it out of self-hatred and started to realize that applied to me as well”; “I was deeply uncomfortable with my secondary sex characteristics, which I now understand was a result of childhood trauma and associating my secondary sex characteristics with those events.”

Despite the absence of any questions about this topic in the survey, nearly a quarter (23.0%) of the participants expressed the *internalized homophobia and difficulty accepting oneself as lesbian, gay, or bisexual* narrative by spontaneously describing that these experiences were instrumental to their gender dysphoria, their desire to transition, and their detransition. All

of the participants in this category indicated that they were either same-sex attracted exclusively or were same-sex attracted in combination with opposite-sex attraction (such as bisexual, pansexual, etc.). The following responses were written in as “other” for the question about why participants transitioned: “Transitioning to male would mean my attraction to girls would be ‘normal’”; “being a ‘gay trans man’ (female dating other females) felt better than being a lesbian, less shameful”; “I felt being the opposite gender would make my repressed same-sex attraction less scary”; “I didn’t want to be a gay man.” Some participants described that it took time for them to gain an understanding of themselves as lesbian, gay, or bisexual as seen in the following: “At the time I was trying to figure out my identity and felt very male and thought I was transgender. I later discovered that I was a lesbian...”; and “Well, after deep discovery, I realized I was a gay man and realized that a sexual trauma after puberty might [have] confused my thought. I wanted to live as a gay man again.” Several natal female respondents expressed that seeing other butch lesbians would have been helpful to them as shown by the following: “What would have helped me is being able to access women’s community, specifically lesbian community. I needed access to diverse female role-models and mentors, especially other butch women.”

The *social influence* narrative was identified where participants added information to the question about if they had felt pressured to transition and the response described pressure from a person or people. One-fifth (20.0%) of participants expressed that they felt pressured by a person or people to transition. Example quotes for social influence were described in a previous section.

Of the natal females, 7.2% expressed the *misogyny* narrative. Example quotes include: “...I realized how much of it [dysphoria] may have been caused by internalized misogyny and homophobia”; “Finally realizing there’s nothing wrong or disgusting or weak about being female”; and “My transition was a desperate attempt to distance myself from womanhood and femaleness due to internalized lesbophobia and misogyny combined with a history of sexual trauma.”

After Detransition

Disposition. At the time of survey completion, most participants had returned to identifying solely as their birth sex (61.0%) with an additional 10.0% identifying as their birth sex plus another identification. Fourteen percent of the participants identified solely as nonbinary with an additional 11.0% identifying as nonbinary plus a second identification. Eight percent of the participants identified solely as transgender with an additional 5.0% identifying as transgender plus another identification. Four percent of the responses did not fit into the above categories and were coded as “other.” Figure 1 illustrates the distribution of participants’ current gender identification (post-detransition). Only 24.0% of participants had informed

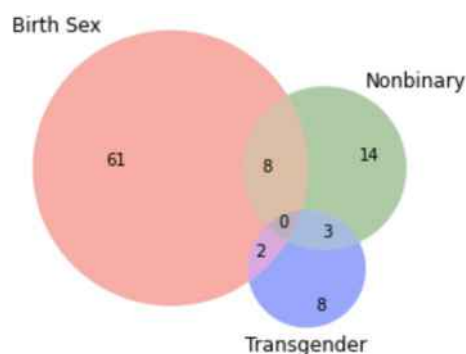


Fig. 1 Distribution of participants’ current gender identification (after detransition) (n=100). *Notes:* The sum of the numbers appearing in the “Birth Sex” circle indicates the number of participants who returned to identifying with their birth sex (71)—either as birth sex alone (61) or birth sex in addition to a second identification (10) represented in the overlap between two circles. For example, eight participants identify as their birth sex and as nonbinary. The sum of the numbers appearing in the “Nonbinary” circle indicates the number of participants who identify as nonbinary (25)—either as nonbinary alone (14) or nonbinary in addition to a second identification (11). The sum of the numbers appearing in the “Transgender” circle indicates the number of participants who identify as transgender (13)—either as transgender alone (8) or transgender in addition to a second identification (5). Four participants had responses that did not fit the categories above and were coded as “other”

the doctor or clinic that facilitated their transitions that they had detransitioned.

Self-appraisal of past transgender identification. Table 7 presents the data for responses endorsed by participants to reflect how they feel currently about having identified as transgender in the past. The statements most frequently selected included: “I thought gender dysphoria was the best explanation for what I was feeling” (57.0%), “My gender dysphoria was similar to the gender dysphoria of those who remain transitioned” (42.0%), “What I thought were feelings of being transgender actually were the result of trauma” (36.0%), “What I thought were feelings of being transgender actually were the result of a mental health condition” (36.0%).

Self-appraisal of transition and detransition. When asked to select which statement best reflects their feelings about their transition, nearly a third (30.0%) indicated that they wish they had never transitioned while 11.0% indicated they were glad they transitioned. Some (34.0%) selected the statement that transition “was a necessary part of [their] journey” but others (21.0%) indicated that the process of transitioning distracted them from what they should have been doing. Responses about whether transition helped or harmed them were also complicated. While 50.5% selected answers consistent with being both helped and harmed, 32.3% indicated that they were only harmed and 17.2% indicated that they were only helped. The majority of respondents were dissatisfied with their decision to transition (69.7%) and satisfied with their decision to detransition (84.7%). At least some amount of transition regret was

Table 7 Self-appraisal of past transgender identification

	Natal female <i>N</i> (%) <i>N</i> = 69	Natal male <i>N</i> (%) <i>N</i> = 31
<i>Self-appraisal about identifying as transgender in the past*</i>		
I thought gender dysphoria was the best explanation for what I was feeling	39 (56.5%)	18 (58.1%)
My gender dysphoria was similar to the gender dysphoria of those who remain transitioned	32 (46.4%)	10 (32.3%)
What I thought were feelings of being transgender actually were the result of trauma	31 (44.9%)	5 (16.1%)
What I thought were feelings of being transgender actually were the result of a mental health condition	28 (40.6%)	8 (25.8%)
Someone else told me that the feelings I was having meant that I was transgender and I believed them	25 (36.2%)	10 (32.3%)
I still identify as transgender	20 (29.0%)	10 (32.3%)
I believed I was transgender then, but I was mistaken	16 (23.2%)	6 (19.4%)
I was transgender then but I am not transgender now	15 (21.7%)	7 (22.6%)
I formerly identified as transgender and now identify as genderqueer/nonbinary	12 (17.4%)	5 (16.1%)
My gender dysphoria was different from the gender dysphoria of those who remain transitioned	11 (15.9%)	4 (12.9%)
I was never transgender	8 (11.6%)	3 (9.7%)
I thought I had gender dysphoria but I was mistaken	4 (5.8%)	4 (12.9%)
I never had gender dysphoria	1 (1.4%)	2 (6.5%)
N/A as I did not identify as transgender in the past	0 (0%)	1 (3.2%)
Other	18 (26.1%)	5 (16.1%)

*May select more than one answer

common (79.8%) and nearly half (49.5%) reported strong or very strong regret. Most respondents (64.6%) indicated that if they knew then what they know now, they would not have chosen to transition.

Discussion

This study was designed to explore the experiences of individuals who obtained medical and surgical treatment for gender dysphoria and then detransitioned by discontinuing the medications or having surgery to reverse the changes from transition. The findings of this study, however, should not be assumed to be representative of all individuals who detransition. Although this study further documents that detransitioners exist, the prevalence of detransition as an outcome of transition is unknown. Only a small percentage of detransitioners (24.0%) informed the clinicians and clinics that facilitated their transitions that they had detransitioned. Therefore, clinic rates of detransition are likely to be underestimated and gender transition specialists may be unaware of how many of their own patients have detransitioned, particularly for patients who are no longer under their care.

This research demonstrates that the experiences of individuals who detransition are varied and the reasons for detransition are complex. Nearly all participants identified as transgender or nonbinary at the start of their transition and most sought transition because they did not want to be associated with their natal

sex, their bodies felt wrong the way they were, and they believed that transition was the only option to relieve their distress. Some were helped by transition and only detransitioned because they were pressured to do so by people in their lives, society, or because they had medical complications. Some were harmed by transition and detransitioned because they concluded that their gender dysphoria was caused by trauma, a mental health condition, internalized homophobia, or misogyny—conditions that are not likely to be resolved with transition. These findings highlight the complexity of gender dysphoria and suggest that, in some cases, failure to explore co-morbidities and the context in which the gender dysphoria emerged can lead to misdiagnosis, missed diagnoses, and inappropriate gender transition. Some individuals detransitioned because their gender dysphoria resolved, because they found better ways to address their symptoms, or because their personal definitions of male and female changed and they became comfortable identifying as their natal sex.

The study sample was predominantly young natal females, many of whom experienced late-onset gender dysphoria which mirrors the recent, striking changes in the demographics of gender dysphoric youth seeking care as well as the youth described by their parents in Littman (2018) (see also Aitken et al., 2015; de Graaf et al., 2018; Zucker, 2019). Concerns have been raised that this new cohort of gender dysphoric individuals is unlike previous cohorts. Professionals have started to call for caution before treating this cohort with interventions with permanent effects because the etiologies, desistance and persistence rates,

expected duration of symptoms, and whether this new population is helped or harmed by gender transition is still unknown (D'Angelo et al., 2021; Kaltiala-Heino et al., 2018). The natal females and natal males in this sample differed on several dimensions, including that natal females were younger than natal males when they sought transition, when they decided to detransition, and at the time of survey completion. Natal females were more likely than natal males to have experienced a trauma less than one year before the onset of their gender dysphoria and were more likely to have felt pressured to transition. Compared to natal males, natal females remained transitioned for a shorter duration of time before deciding to detransition. Additionally, natal females transitioned more recently than natal males, so their experiences may vary due to changing trends in the clinical management of gender dysphoria and the cultural settings in which they became gender dysphoric.

The study findings covered a wide range of detransition experiences that are consistent with the diversity of experiences described in previously published clinical case reports and case series. Overlap of findings include: transition regret; absence of transition regret; re-identification with birth sex; continued identification as transgender; improvement or worsening of well-being with transition; retransitioning; detransitioning due to external social pressures; nonbinary identification; and recognizing and accepting oneself as homosexual or bisexual (D'Angelo, 2018; Djordjevic et al., 2016; Levine, 2018; Pazos Guerra et al., 2020; Turban & Keuroghlian, 2018; Turban et al., 2021; Vandenbussche, 2021). The population in this study is similar to the population in Vandenbussche in that both were predominantly natal females in their mid-20s. Because the current study recruited in 2016–2017 and Vandenbussche recruited in 2019, the similar mean age of participants may reflect the age of individuals who can be reached in online detransitioner communities. Several findings in this study were consistent with Vandenbussche's findings, including similar reasons for detransition (realizing that their gender dysphoria was related to other issues, finding alternatives to address gender dysphoria, gender dysphoria resolved, etc.). Although these two studies were recruited in different years, had different eligibility criteria, and included participants from several countries, it is possible that there may be some overlap of study populations.

The current study findings provide additional insight into the complex relationships between internalized homophobia, gender dysphoria, and desire to transition. Contrary to arguments against the potential role of homophobia in gender transitions (Ashley, 2020), participants reported that their own gender dysphoria and desire to transition stemmed from the discomfort they felt about being same-sex attracted, their desire to not be gay, and the difficulties that they had accepting themselves as lesbian, gay or bisexual. For these individuals, exploring their distress and discomfort around sexual orientation issues may have been more helpful to them than medical and surgical transition or at least an important part of exploration before making

the decision to transition. This research adds to the existing evidence that gender dysphoria can be temporary (Ristori & Steensma, 2016; Singh et al., 2021; Zucker, 2018). It has been established that the most likely outcome for prepubertal youth with gender dysphoria is to develop into lesbian, gay, bisexual (LGB) (non-transgender) adults (Ristori & Steensma, 2016; Singh et al., 2021; Wallien & Cohen-Kettenis, 2008; Zucker, 2018). And, temporary gender dysphoria may be a common part of LGB identity development (Korte et al., 2008; Patterson, 2018). Therefore, intervening too soon to medicalize gender dysphoric youth risks iatrogenically derailing the development of youth who would otherwise grow up to be LGB non-transgender adults. Participants who detransitioned because they became comfortable identifying as their natal sex and because their gender dysphoria resolved further support that gender dysphoria is not always permanent.

The data in this study strengthen, with first-hand accounts, the rapid-onset gender dysphoria (ROGD) hypotheses which, briefly stated, are that psychosocial factors (such as trauma, mental health conditions, maladaptive coping mechanisms, internalized homophobia, and social influence) can cause or contribute to the development of gender dysphoria in some individuals (Littman, 2018). Littman also postulated that certain beliefs could be spread by peer contagion, including the belief that a wide range of symptoms should be interpreted as gender dysphoria (and proof of being transgender) and the belief that transition is the only solution to relieve distress. The current study supports the potential role of psychosocial factors in the development of gender dysphoria and further suggests, by participant responses that transitioning prevented or delayed them from addressing their underlying conditions, that maladaptive coping mechanisms may be relevant for some individuals. The potential role of social influence is demonstrated as well. First, when respondents were asked to describe how they currently feel about having identified as transgender in the past, more than a third endorsed the option, "Someone told me that the feelings I was having meant that I was transgender, and I believed them." Second, a subset of participants experienced the unique friendship group dynamics reported in Littman where peer groups mocked people who were not transgender and popularity within the friend group increased when respondents announced their plan to transition. Additionally, respondents identified several social sources that encouraged them to believe that transitioning would help them including: YouTube transition videos, blogs, Tumblr, and online communities. And finally, 20.0% of participants felt pressured to transition by social sources that included friends, partners, and society. More research is needed to further explore these hypotheses.

The current study and the Turban et al. (2021) analysis of the USTS data share some similarities and differences. Similarities include the use of convenience samples, targeted recruitment, and anonymous data collection. The findings of Turban et al. (including external pressures to detransition and transgender

identification after detransition) are a subset of the array of experiences described in the current study. The current study differed from James et al. (2016) and Turban et al. in that it enrolled participants based on the criterion of detransition after medical or surgical transition regardless of how they currently identified, recruited from communities with diverse perspectives about transition and detransition, used a precise definition for detransition that specifies the use of medication or surgery, and included answer options that were relevant to many different types of detransition experiences. In contrast, the USTS only enrolled transgender-identifying individuals regardless of whether they medically or surgically transitioned, recruited from communities likely to have similar perspectives about transition and detransition, and provided multiple choice answer options that were relevant to a narrower range of detransition experiences (James et al., 2016). Further, the definition used by the USTS for “detransitioned” (having “gone back to living as [their] sex assigned as birth, at least for a while”) is quite vague. Although Turban et al. provide valuable information about the subset of transgender-identifying people who may have detransitioned, the current study provides a more comprehensive view of individuals who detransition after medical or surgical transition.

Over the past 15 years, there have been substantial changes in the clinical approach to gender dysphoric patients notable for a shift from approaches that employ thorough evaluations and judicious use of medical and surgical transition (the watchful waiting or Dutch approach, the developmentally informed approach, and the medical model of care) to approaches with minimized or eliminated evaluation and liberal use of transition interventions (the affirmative approach and the informed consent model of care) (Cavanaugh et al., 2016; de Vries & Cohen-Kettenis, 2012; Meyer et al., 2002; Rafferty et al., 2018; Schulz, 2018; Zucker et al., 2012b). This trend is prominent in the U.S. where the American Academy of Pediatrics endorsed the affirmative approach in 2018 and Planned Parenthood currently uses the informed consent model to provide medical transition in more than 200 clinics in 35 states (Planned Parenthood, 2021; Rafferty et al., 2018). It is plausible that an unintended consequence of these clinical shifts may be an increase in people who detransition. Many participants in this study believe that they did not receive an adequate evaluation by a clinician before transition. The definition of “adequate evaluation” was not provided in the survey and may be open to respondent interpretation. But given the complexities of the gender dysphoria described in the current study, one might consider a low bar of “adequate” to be the exploration of factors that could be misinterpreted as non-temporary gender dysphoria as well as factors that could be underlying causes for gender dysphoria. The most recently emerging approach to gender dysphoria is called the “exploratory approach” which is a neutral psychotherapeutic approach to help individuals gain a deeper understanding of their gender distress and the factors contributing to

their dysphoria (Churcher Clarke & Spiliadis, 2019; Spiliadis, 2019). The study’s findings suggest that an exploratory type of approach may have been beneficial to some of the respondents. Future research is needed to determine which patients are best treated by which approaches long term.

Patients considering medical and surgical interventions deserve accurate information about the risks, benefits, and alternatives to that treatment. In this sample, nearly half of the participants reported that the counseling they received about transition was overly positive about the benefits of transition and more than a quarter reported that the counseling was not negative enough about the risks. Several participants felt pressured to transition by their doctors and therapists. If these types of clinical interactions are verified, exploration is needed to determine the extent to which this situation occurs and what measures might be taken to ensure that clinicians provide patients with their options accurately and dispassionately.

There are several obstacles to obtaining accurate rates of detransition and desistance, including stigma and the low numbers of detransitioners who inform their clinicians that they detransitioned. One approach to bypass some of these barriers would be to incorporate non-judgmental questions about detransition and desistance into nationally representative surveys that collect health data. For example, the Behavioral Risk Factor Surveillance System contains an optional module about sexual orientation and gender identity that includes two questions to explore gender issues (Downing & Przedworski, 2018). By changing one existing question, “Do you consider yourself to be transgender?” into two questions, “Have you ever, at any point in your life, considered yourself to be transgender?” and “Do you currently consider yourself to be transgender?” and by adding a follow-up question if answers indicate past but not current transgender identification, “Did you ever take puberty blockers, cross-sex hormones, anti-androgens, or have any surgery as part of your transition?”, valuable information about desistance, detransition, and current transgender identification could be obtained. These types of questions may also be of use in clinical practice and electronic medical records. The information gained about rates of detransition and desistance would enhance transgender healthcare by aiding informed consent processes at the start of any medical or surgical transition.

One of the strengths of this study is that it is one of the largest samples of detransitioners to date. Other strengths include the use of a precise definition for detransition, enrollment of detransitioners regardless of their post-detransition gender identification, recruitment from communities with likely divergent views about transition and detransition, and collaboration with two individuals who had detransitioned which helped to create a survey instrument with questions relevant to a variety of detransition experiences and enhanced the recruitment efforts.

There are several limitations to this study that should be considered when interpreting the findings. Like Vandenbussche (2021), James et al. (2016), and Turban et al. (2021), this study

used a cross-sectional design, anonymous surveying, and a convenience sample and therefore shares the same limitations that are inherent to these methodologies. These limitations include that conclusions about causation cannot be determined, identities of participants cannot be verified, and the findings of this study may not be generalizable to the entire population of people who detransition or to people outside of the countries where participants were from. Although this study reached out to communities with differing perspectives about transition and detransition, targeted recruitment and convenience samples always introduce the limitations associated with selection biases which should be addressed in future research. Finally, many of the participants in this study had less than ideal outcomes to their medical and surgical transitions, and it is possible that these experiences may have colored some of the responses.

Additional research is needed to determine the prevalence of detransition as an outcome of transition and to identify and meet the psychological and medical needs of the emerging detransitioned population. Because many individuals who detransition re-identify with their birth sex, are no longer connected to LGBT communities, and don't return to gender clinics, future research about detransition needs to expand recruitment efforts beyond gender clinics and transgender communities. The development and testing of non-medical interventions for gender dysphoria could provide valuable options to be used as alternatives or in conjunction with medical and surgical treatments. Because of the potential for some to experience trauma, mental health conditions, internalized homophobia, and misogyny as gender dysphoria, research needs to be conducted on the evaluation process before transition to find approaches that respectfully and collaboratively explore factors that might contribute to gender-related distress. There continues to be an absence of long-term outcomes evidence for youth treated with medical and surgical transition and a lack of information about the trajectories of youth experiencing late-onset gender dysphoria—research is needed to address these gaps. Continued work is needed to reduce rigid gender roles, increase representation of gender stereotype nonconformity, and to address discrimination and social pressures exerted against people who are transgender, lesbian, gay, bisexual, and gender stereotype non-conforming.

Conclusion

This study described individuals who, after transitioning with medications or surgery, have detransitioned. The prevalence of detransitioning after transition is unknown but is likely underestimated because most of the participants did not inform the doctors who facilitated their transitions that they had detransitioned. There is no single narrative to explain the experiences of all individuals who detransition and we should take care to avoid painting this population with a broad brush. Some detransitioners return to identifying with their birth sex, some assume

(or maintain) a nonbinary identification, and some continue to identify as transgender. Some detransitioners regret transitioning and some do not. Some of the detransitioners reported experiences that support the ROGD hypotheses, including that their gender dysphoria began during or after puberty and that mental health issues, trauma, peers, social media, online communities, and difficulty accepting themselves as lesbian, gay, or bisexual were related to their gender dysphoria and desire to transition. Natal female and natal male detransitioners appear to have differences in their baseline characteristics and experiences and these differences should be further delineated. Future research about gender dysphoria and the outcomes of transition should consider the diversity of experiences and trajectories. More research is needed to determine how best to provide support and treatment for the long-term medical and psychological well-being of individuals who detransition. Findings about detransition should be used to improve our understanding of gender dysphoria and to better inform the processes of evaluation, counseling, and informed consent for individuals who are contemplating transition.

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Declarations

Conflict of interest The author has no relevant financial or non-financial conflicts of interest to disclose.

Consent to Participate Electronic consent was obtained from all participants included in the study. On the first page of the online survey, participants were informed of the research purpose and potential risks and benefits of participating, that their participation was voluntary, and were presented with a way to contact the researcher. The research survey questions were displayed only if the participant clicked “agree” which indicated that the participant read the information, voluntarily agreed to participate, and were at least 18 years of age.

Ethical Approval The research was determined to be Exempt Human Research by the Program for the Protection of Human Subjects of the Icahn School of Medicine at Mount Sinai in New York, NY. All procedures were performed in accordance with the ethical standards of the Program for the Protection of Human Subjects at the Icahn School of Medicine at Mount Sinai and with the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

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Detransition-Related Needs and Support: A Cross-Sectional Online Survey

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Detransition-Related Needs and Support: A Cross-Sectional Online Survey

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ABSTRACT

The aim of this study is to analyze the specific needs of detransitioners from online detrans communities and discover to what extent they are being met. For this purpose, a cross-sectional online survey was conducted and gathered a sample of 237 male and female detransitioners. The results showed important psychological needs in relation to gender dysphoria, comorbid conditions, feelings of regret and internalized homophobic and sexist prejudices. It was also found that many detransitioners need medical support notably in relation to stopping/changing hormone therapy, surgery/treatment complications and reversal interventions. Additionally, the results indicated the need for hearing about other detransitioners' experiences and meeting each other. A major lack of support was reported by the respondents overall, with a lot of negative experiences coming from medical and mental health systems and from the LGBT+ community. The study highlights the importance of increasing awareness and support given to detransitioners.

KEYWORDS

Detransition; gender dysphoria; gender identity; cross-sex hormones; detransitioners; transgender; transition; support

Introduction

In recent years, there has been an increasing interest in the phenomenon of detransition. Many testimonies have been shared by self-identified detransitioners online and detrans communities have formed on social media. This phenomenon started to attract the attention of scholars, who have emphasized the need for research into the specific needs of this group (e.g., Butler & Hutchinson, 2020; Entwistle, 2020; Hildebrand-Chupp, 2020). A few case studies have been conducted in order to explore individual experiences of detransition (Pazos-Guerra et al., 2020; Turban & Keuroghlian, 2018). The latter studies highlighted the complexity of detransition experiences but did not provide sufficient data to assess the general needs and characteristics of detransitioners. The current study aims to explore this issue in more depth and to serve as a basis for future research on the phenomenon of detransition.

To date there has been little agreement on a definition of the word “detransition.” As explained by Expósito-Campos (2021), this term has been used interchangeably to refer to what he perceives to be two distinctive situations: in

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the first, the detransitioning individual stops identifying as transgender; in the second, they do not. It is therefore necessary here to clarify exactly what is meant when writing about detransition.

In this paper, I will be using the following concepts: “medical detransition,” “social detransition” and (male or female) “detransitioner.” Medical detransition refers to the process of ceasing/reversing the medical aspects of one’s medical transition. This might include stopping or changing hormone therapy and undergoing reversal surgeries, among others. Likewise, social detransition refers to the process of changing/undoing the social aspects of one’s social transition. For example, it might include presenting oneself as one’s birth sex again, changing one’s post-transition name or going back to using the pronouns associated with one’s birth sex.

The term “detransitioner” will be used here to refer to someone who possibly underwent some of these medical and/or social detransition steps and, more importantly, who identifies as a detransitioner. It is important to add this dimension, because the act of medical/social detransition can be performed by individuals who did not cease to identify as transgender and who do not identify as detransitioners or as members of the detrans community. Furthermore, some individuals might identify as detransitioners after having ceased to identify as trans, while not being in a position to medically or socially detransition due to medical or social concerns. As Hildebrand-Chupp (2020) puts it: “[B]ecoming a detransitioner involves a fundamental shift in one’s subjective understanding of oneself, an understanding that is constructed within these communities.” (p.802). More qualitative research should be conducted in order to better understand how members of the detrans community define themselves and make sense of their own detransition process. However, this goes beyond the scope of this study.

The creation of support and advocacy groups for detransitioners in recent years (e.g., DetransCanada, [n.d.](#), Detrans Voices, [n.d.](#), The Detransition Advocacy Network, [n.d.](#), Post Trans, [n.d.](#)) testifies to the formation of a detrans community whose members have specific needs. Scholars and clinicians have recently started raising concerns around the topic (e.g., Butler & Hutchinson, 2020; Entwistle, 2020; Hildebrand-Chupp, 2020; Marchiano, 2020). However, little research has been done specifically into the characteristics of this seemingly growing community.

Two informal surveys conducted by detransitioners (Hailey, 2017; Stella, 2016) have explored the demographics and (de)transition experiences of members of online female detrans communities. These will constitute interesting points of comparison in the discussion section of the current research.

The purpose of this exploratory study is to offer an overview of the current needs of detransitioners from online detrans communities, which will hopefully serve as a useful basis for further experimental studies around the topic of detransition. The current research primarily seeks to address the following

questions: What are the current needs of detransitioners? What support is given to detransitioners in order to fulfil these needs?

Methods

Procedure

A cross-sectional survey was conducted, using online social media to recruit detransitioners. Access to the questionnaire was open from the 16th of November until the 22nd of December 2019. Any detransitioner of any age or nationality was invited to take part in the study. The survey was shared by Post Trans (www.post-trans.com)—a platform for female detransitioners—via public posts on Facebook, Instagram and Twitter. Participants were also recruited through private Facebook groups and a Reddit forum for detransitioners (r/detrans). Some of the latter platforms were addressed exclusively to female detransitioners. The purpose of the study was presented as gaining a better understanding of detransitioners' current needs. Potential participants were asked to fill out the form and share it to fellow detransitioners. All participants have been fully anonymized.

Everyone who answered “yes” to the question “Did you transition medically and/or socially and then stopped?” was selected in the study. The individual questionnaires of the 9 respondents who answered “no” to this question were looked at closely, in order to assess whether they should be included in the study. Eight of them were added to the final sample, as their other answers indicated that their experiences lead them to identify as detransitioners.

This research was approved by the Ethics Committee for Noninvasive Research on Humans in the Faculty of Society and Economics of the Rhine-Waal University of Applied Sciences

Questionnaire design

The questionnaire consisted of 24 questions (see [Appendix](#)). The first series of questions was aimed at defining the profile of the respondent (age, sex, country, etc.), the second was asking about relevant aspects of transition and detransition experiences (transition type, gender dysphoria, therapy, medical interventions, reasons for detransitioning etc.), and the third focused on the needs encountered as well as the support (or lack of) received during the process of detransition (medical, psychological, legal and social needs and support).

Most of the items were multiple-choice questions. The conception of the multiple choices was based on observations drawn from several detransition online resources and forums. An open “other” category was available when relevant for the respondents to write in possibly lacking options. The survey

was designed to leave a lot of free space to add answers, since the detransition population is still very much under-researched and there is a lot to learn from each of its members. This is why a more qualitative approach was taken for the last question notably, leaving an open field for adding comments about the support—or lack of—received while detransitioning. This qualitative data was analyzed through the identification of recurrent themes, which will be presented in the results section.

Participants

A total of 237 participants were included in the final sample. The large majority was female; 217 female (92%) for 20 male respondents (8%). This was determined based on the answers to the question: “What sex were you assigned at birth?” The average age was 25.02 years ($SD = 7.72$), ranging from 13 to 64. The mean age of female detransitioners ($M = 24.38$; $SD = 6.86$) was lower than that of male detransitioners ($M = 31.95$; $SD = 12.26$).

Around half of the sample (51%) reported coming from the United States and close to a third from Europe (32%). Fifteen respondents are from Canada (6%), twelve from Australia (5%), and one from each of the following countries: Brazil, Kazakhstan, Mexico, Russia and South Africa.

Close to two thirds (65%) transitioned both socially and medically; 31% only socially. A few respondents rightly criticized the fact that the option of medically transitioning only was not available in the questionnaire. The absence of this option needs to be kept in mind when looking at the results.

Around half (51%) of the respondents started socially transitioning before the age of 18, and a quarter (25%) started medically transitioning before that age as well. The average age of social transition was 17.96 years (17.42 for females; 23.63 for males) ($SD = 5.03$) and that of medical transition was 20.70 years (20.09 for females; 26.19 for males) ($SD = 5.36$). Fourteen percent of the participants detransitioned before turning 18. The average age of detransition was 22.88 years (22.22 for females; 30.00 for males) ($SD = 6.46$). The average duration of transition of the respondents (including both social and medical transition) was 4.71 years (4.55 for females; 6.37 for males) ($SD = 3.55$).

Eighty percent of the male detransitioners underwent hormone therapy, compared to 62% for female detransitioners. Out of the respondents who medically transitioned, 46% underwent gender affirming surgeries.

Results

For sake of clarity, the results will be presented based on the three categories mentioned above in the methods section: profile of the respondents, relevant aspects of transition and detransition and, finally, detransition-related needs and support. The qualitative results will be displayed at the end of this section.

Profile of the respondents

Most of the information related to the profile of the respondents can be found in the methods section. The sample showed a high prevalence of comorbidities, considering that over half of the participants (54%) reported having had at least 3 diagnosed comorbid conditions (out of the 11 conditions listed in the survey—see Table 1). The most prevalent diagnosed comorbid conditions are depressive disorders (69%) and anxiety disorders (63%), including PTSD (33%) (see Table 1).

Relevant aspects of transition and detransition

A great majority of the sample (84%) reported having experienced both social and body dysphoria. (Social dysphoria being defined as a strong desire to be seen and treated as being of a different gender, and body dysphoria as a strong desire to have sex characteristics of the opposite sex/rejection of your own sex). Eight percent reported having experienced only body dysphoria, 6% only social dysphoria and 2% neither of them.

Forty-five percent of the whole sample reported not feeling properly informed about the health implications of the accessed treatments and interventions before undergoing them. A third (33%) answered that they felt partly informed, 18% reported feeling properly informed and 5% were not sure.

The most common reported reason for detransitioning was realized that my gender dysphoria was related to other issues (70%). The second one was health concerns (62%), followed by transition did not help my dysphoria (50%), found alternatives to deal with my dysphoria (45%), unhappy with the social changes (44%), and change in political views (43%). At the very bottom of the list are: lack of support from social surroundings (13%), financial concerns (12%) and discrimination (10%) (see Figure 1).

34 participants (14%) added a variety of other reasons such as absence or desistance of gender dysphoria, fear of surgery, mental health concerns related

Table 1. Number of participants with comorbid conditions.

Comorbid condition	Diagnosed	Suspected
Depressive disorder	163 (70%)	32 (14%)
Anxiety disorder	149 (63%)	43 (18%)
Post-traumatic stress disorder	79 (33%)	63 (27%)
Attention deficit disorder	57 (24%)	50 (21%)
Autism spectrum condition	47 (20%)	61 (26%)
Eating disorder	46 (19%)	58 (25%)
Personality disorder	40 (17%)	26 (11%)
Obsessive compulsive disorder	35 (15%)	44 (19%)
Polycystic ovary syndrome (only females)	22 (10%)	13 (6%)
Dissociative identity disorder	14 (6%)	23 (10%)
Schizo-spectrum disorder	5 (2%)	9 (4%)

“Diagnosed” and “Suspected” were mutually exclusive categories.

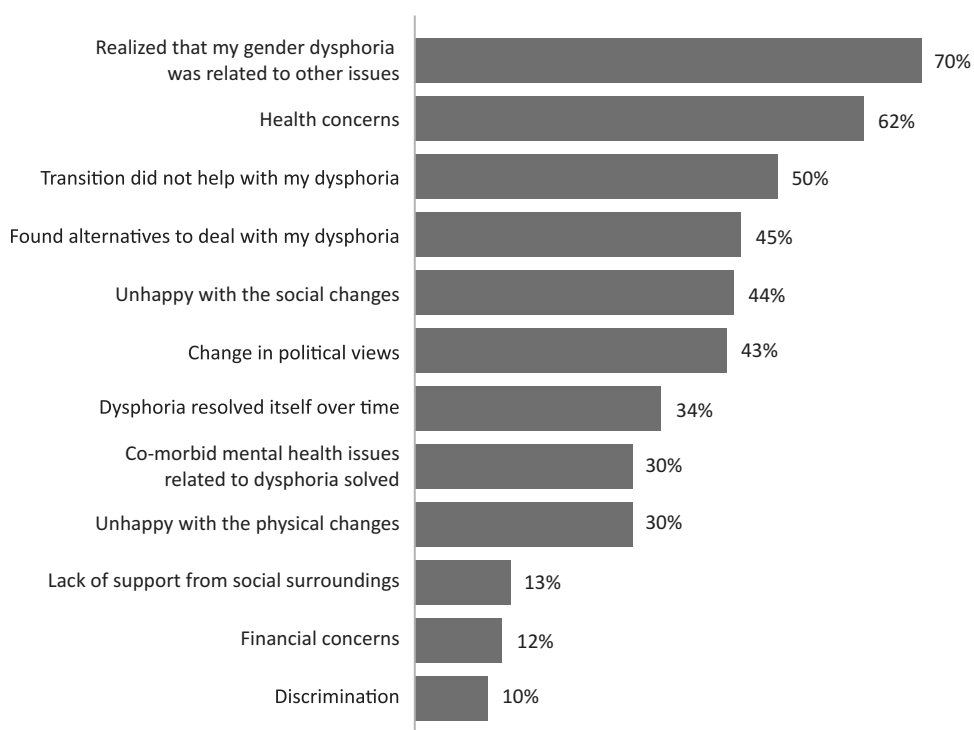


Figure 1. Reasons for detransitioning.

to treatment, shift in gender identity, lack of medical support, dangerosity of being trans, acceptance of homosexuality and gender non-conformity, realization of being pressured to transition by social surroundings, fear of surgery complications, worsening of gender dysphoria, discovery of radical feminism, changes in religious beliefs, need to reassess one’s decision to transition, and realization of the impossibility of changing sex.

Detransition-related needs and support

The different types of needs were divided into four categories in the questionnaire: medical, psychological, legal and social needs.

Medical needs

The most commonly chosen answer was the need for receiving accurate information on stopping/changing hormonal treatment (49%), followed by receiving help for complications related to surgeries or hormonal treatment (24%) and receiving information and access to reversal surgeries/procedures (15%). Forty-six percent of the participants reported not having any detransition-related medical need. Sixteen respondents (7%) added another non-listed answer, such as tests to determine current reproductive health, information

about long-term effects of hormone therapy, about the health consequences of having had a full hysterectomy and about pain related to chest binding.

Psychological needs

Psychological needs appeared to be the most prevalent of all, with only 4% of the respondents reporting not having any. The answers working on comorbid mental issues related to gender dysphoria and learning to cope with gender dysphoria; finding alternatives to medical transition are at the top of the list, both with 65%. Below that, learning to cope with feelings of regret (60%), followed by learning to cope with the new physical and/or social changes related to detransitioning (53%) and learning to cope with internalized homophobia (52%). Thirty-four respondents (14%) added another non-listed answer, such as trauma therapy, learning how to deal with shame and internalized misogyny, how to cope with rejection from the LGBT and trans communities and how to deal with the aftermath of leaving a manipulative group. Other answers disclosed the need for help recovering from addictive sexual behavior related to gender dysphoria, psychosexual counseling and peer support.

Legal needs

More than half of the sample (55%) reported not having any detransition-related legal need. The main legal need expressed was changing back legal gender/sex marker and/or name (40%), followed by legal advice and support to take legal action over medical malpractice (13%). Five respondents (2%) added another non-listed answer, such as employment legal aid and support to take legal action for having been forced to go through a sterilization.

Social needs

The big majority of the respondents reported a need for hearing about other detransition stories (87%). The second most common answer was getting in contact with other detransitioners (76%), followed by receiving support to come out and deal with negative reactions (57%). Thirty-three respondents (14%) added another non-listed answer such as being accepted as female while looking male, help navigating social changes at the workplace, building a new social network, more representation of butch lesbians, real life support and finding a community.

When looking at from whom the respondents received support while transitioning and detransitioning, it appears that the biggest source of help comes from online groups/forums/social media for both transition and detransition (65%). The support received from friends, partner(s) and family is a little higher for detransition (64%) than for transition (56%).

Only 8% of the respondents reported having received help from an LGBT+ organization while detransitioning, compared to 35% while transitioning.

Similarly, 5% reported having received help from a trans-specific organization while detransitioning, compared to 17% while transitioning.

A total of 29% reported having received support for their detransition from the medical professionals that helped them during their transition. In contrast, 38% sought support from a new therapist/doctor. A part of the sample reported not receiving help from anybody for transitioning (8%) and for detransitioning (11%) (see Figure 2).

Around half of the respondents (51%) reported having the feeling of not having been supported enough throughout their detransition, 31% said they did not know and 18% answered that they had received enough support.

Qualitative results

Two open-ended questions allowed participants to write more extensively about their needs and support in the questionnaire. The first one enabled the respondents to write about any additional need that they encountered while detransitioning, while the second asked about the support—or lack of—that they had received.

Additional comments about needs

Thirty-seven participants (16%) left various comments about specific needs that they experienced during their transition and detransition.

Several respondents expressed the need for different types of therapy and counseling for dealing with issues of dissociation, childhood sexual trauma, anorexia, relationship issues and body issues caused by irreversible gender affirming surgeries. A participant also mentioned the importance of help revolving around suicide prevention for those who need it.

Additionally, someone emphasized the need for therapists to validate the feelings of being harmed by transition that some detransitioners experience, rather than dismissing or opposing them. Similarly, another respondent expressed the need for non-judgmental medical practitioners. Someone else described the need for as much medical autonomy as possible and a total freedom from psychology and psychiatry. A participant also explained that she would have needed to know the health risks of chest binding before experiencing them.

Furthermore, two respondents highlighted the need to look into individual experiences and needs without forcing them into a rigid model of transition. Others wrote about the need for more information about detransition and a better general understanding of this phenomenon.

Lastly, a few female detransitioners expressed the need for being valued as a woman, for learning about feminist theories and for more gender-nonconforming role models.

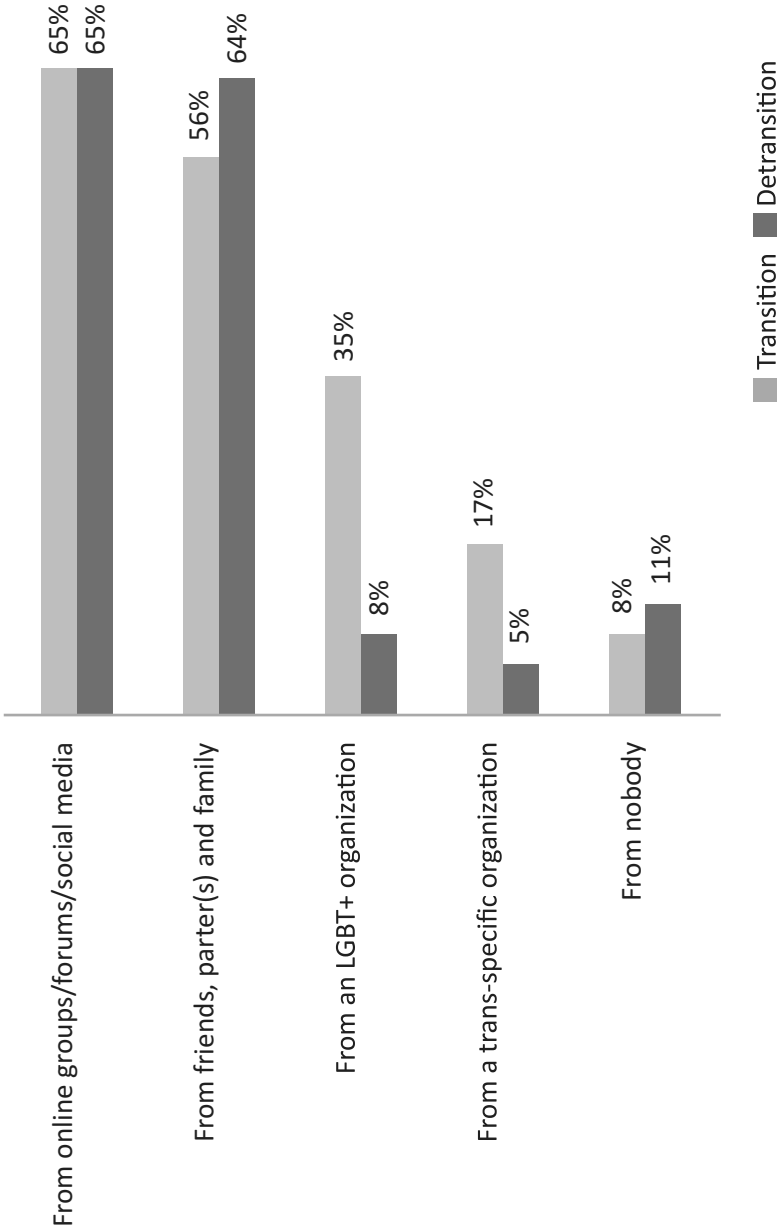


Figure 2. Comparison between transition and detransition support.

Additional comments about support

At the end of the questionnaire, a second open-ended question invited the participants to give further comments about the support—or lack of—that they had received during their detransition process.

A third of the participants (34%) answered this question, often with long and detailed accounts of their personal experiences with regard to this aspect. The most common themes identified were: loss of support from the LGBT community and friends (see Table 2), negative experiences with medical professionals (see Table 3), difficulty to find a detrans-friendly therapist and lack of offered alternatives to transitioning (see Table 4), as well as isolation and lack of overall support. Some gave more positive accounts of the support that they had received from their family, partners and friends and emphasized their important role.

A recurrent theme in the answers was a sense amongst respondents that it was very difficult to talk about detransition within LGBT+ spaces and with trans friends. Many expressed a feeling of rejection and loss of support in relation to their decision to detransition, which lead them to step away from LGBT+ groups and communities (see Table 2).

Whilst a minority reported positive experiences with medical professionals during their detransition, most participants expressed strong difficulties finding the help that they needed during their detransition process. Participants' own descriptions of the nature of these difficulties can be found in Table 3.

Another reported issue was the difficulty of finding a therapist willing and able to look at the factors behind gender dysphoria and to offer alternatives to transitioning. Some respondents highlighted the fact that they were

Table 2. Extracts about experiences of exclusion from LGBT+ communities.

"The LGBT+ community doesn't support detransitioners and I lost all LGBT+ friends I had because they deemed me transphobic/terfy, only non-LGBT+ friends supported me."
"Where I live detransitioners are seen bad for most of the LGBT community, so it's hard to talk about it with freedom."
"It is unacceptable that, at least in my experience, detransition is not something allowed to be talked about in LGBT spaces."
"Only lesbians and feminists helped me. The trans and queer community demonized me and ostracized me for my reidentification."
"I lost a lot of support and attracted a lot of hostility from trans people when I detransitioned socially. I also deal with a lot of people assuming that my dysphoria is gone entirely/cured because I have detransitioned socially, and decided not to go through with medical transition."
"Lgbt organizations don't want to talk about detransition. I did not feel welcome at lgbt events after I detransitioned."
"Telling my trans friends that I'm desisting is nearly impossible. The community is too toxic to allow any kind of discussion about alternatives to transition, sources of dysphoria beyond 'that's just who you are', or stories about detransitioners."
"I've been shunned by most of my trans identifying friends. I had to leave my old doctor, therapist and LGBT group out of shame and embarrassment."
"I have several de-trans friends whom had permanent body alterations they regretted that led to more dysphoria and eventually their suicides. Biggest factors were a lack of medical support and outright rejection from LGBT organisations/communities."
"I still have transgender friends who don't want me to talk about detransition. They're okay with me being detransitioned, but they don't want me to criticize transition or discuss the negative side effects of HRT."

Table 3. Extracts about negative medical experiences during detransition.

"I needed gender and transition experienced providers to assist with my medical detransition, but none of them seemed to understand or provide the type of care I needed, despite my self-advocacy. I got better care from providers outside of the LGBT and transgender specialty clinics."

"I still struggle to find a doctor who has knowledge of detransition and the effects HRT had on me/my best course of action since stopping."

"When I first brought up wanting to stop T to my doctor, they were very dismissive and condescending about it."

"My experience with transition left me with greatly diminished faith in medicine and zero faith in the mental health profession. I now avoid all doctors most of the time (unless I am convinced they are the only way to access a strongly evidence-based treatment or diagnostic tool for a condition which causes more suffering than doctors themselves- many do not) and totally avoid any contact with mental health professionals, and am much better off for it."

"As soon as I 'detransed' I was discharged from all gender services, despite asking for help in dealing with sex dysphoria should it arise again."

"I had no medical help from the doctor who prescribed me T, she wanted nothing to do with me."

"The team that transitioned you is not willing to help you detransition. You need new doctors."

"The medical team that helped me transition is helpful, but they are also causing a lot of hassle, which is very frustrating for me. Like for example they keep me stuck with my male sex marker for I don't know how long, and they don't believe I'm sure enough that I want to detransition, because they think I should have consistent 'reverse dysphoria' and mine kinda isn't so consistent."

"My hormone blocker implant is several years old and is only barely still functioning but they will not remove it. It's in my arm and I have no contact with the doctor because he shut down his business apparently."

Table 4. Extracts about the difficulty of finding a detrans-friendly therapist.

"It is very hard to find a therapist who won't tell you it's 'internalized transphobia' or that dealing with dysphoria in other ways is 'conversion therapy'."

"The only thing that comes to mind is one of the therapists I had, who pushed me not to detransition."

"Therapists are unprepared to handle the detrans narrative and some that I have seen since detransitioning have pushed the trans narrative. Some therapists couldn't tell the difference between being transgender and having internalized misogyny and homophobia."

"I could have benefitted from counseling but don't trust psychologists ideological bias."

"I struggled to find a therapist who supported questioning my trans identity and considering alternatives to transitioning; most only knew how to encourage transitioning and reinforced the harmful ideas that led to my wrongly identifying as FtM in the first place."

"I was doubtful that transition would help my dysphoria before beginning and was assured by multiple professionals that transition was The Solution and proven to work for everyone with dysphoria. A 'gender specialist' therapist flat-out told me that transitioning was the only method of reducing dysphoria that worked when I expressed my desperation for an alternate solution."

"The gender clinic I went to basically told me that the only way to deal with gender dysphoria was transitioning even when I told them I wanted to detransition."

"I struggled to find a therapist who supported questioning my trans identity and considering alternatives to transitioning; most only knew how to encourage transitioning and reinforced the harmful ideas that led to my wrongly identifying as FtM in the first place."

"The biggest issue for me was that when I did try to get support from a therapist or psychologist on entangling the actual reasons behind my dysphoria and how to deal with it, and deal with detransitioning, nobody had any clue or any experience, so they couldn't help me. Which made me even feel more lonely, and made detransitioning so much harder mentally than transitioning was."

cautious regarding the possible ideological bias or lack of knowledge of therapists.

Overall, most respondents explained that their detransition was a very isolating experience, during which they did not receive enough support. However, some participants emphasized the fact that the support that they received from their family, partners and friends, as well as online detrans groups and lesbian and feminist communities was extremely important and valuable to them.

Discussion

The present study was designed to better understand the needs of detransitioners, as well as the support—or lack of—that they are currently receiving. In order to do so, members of online detrans communities were recruited to answer a survey, in which questions were asked about their demographics, their transition and detransition experiences and the needs that they faced as well as the support that they received while detransitioning. In this section, I will discuss the results in relation to the main research question of the current study: What are the needs of detransitioners?

The sample surveyed appeared to be mostly female, young, from Western countries, with an experience of both social and medical transition and a high prevalence of certain comorbid conditions. The current study found that most detransitioners stopped transitioning before their mid-twenties, after an average of 4 years of transition. This observation is consistent with that made by Stella (2016) in her informal study on female detransitioners. The average transition age of the 203 respondents of her survey was 17.09 years, compared to 17.42 years in female detransitioners of the current study. The average detransition age of her sample was 21.09 years, compared to 22.22 years here.

Another finding of the current study was that a majority of the sample underwent hormone therapy (62% for females; 80% for males) and 45% of those who medically transitioned underwent gender affirming surgeries. This is likely to have implications in terms of the medical needs faced by this population. Close to half of the sample (49%) reported a need for receiving accurate information on stopping or changing hormone therapy, and almost a quarter (24%) reported the need for receiving help for complications related to surgeries or hormone therapy. The latter finding is concerning when looking at the negative medical experiences described by respondents in Table 3. Participants recounted situations in which their doctors either did not believe them, did not listen to them, refused them services, or simply did not have the required knowledge to help them during their detransition process. These experiences had a negative impact on some of the participants' trust in healthcare providers.

Similarly, the current study suggested that detransitioners have important psychological needs. This was made visible on the one hand through the fact that a majority of respondents (65%) reported the need for help in working on comorbid mental conditions related to gender dysphoria and in finding alternatives to medical transition. Other needs were reported by a majority of participants, such as learning to cope with feelings of regret (60%), learning to cope with the new physical and/or social changes related to detransitioning (53%) and learning to cope with internalized homophobia (52%). On the other hand, the high prevalence of comorbid conditions described in Table 1 might also be an indicator of important psychological needs. These results are similar

to that found by Hailey (2017) in her informal survey of comorbid mental health in detransitioned females. In her study, 77% reported a diagnosis of a depressive disorder (compared to 70% here), 74% of the sample reported a diagnosis of an anxiety disorder (compared to 63% here), 32% reported a diagnosis of PTSD (compared to 33% here) and 22% reported a diagnosis of an eating disorder (compared to 19% here). This is also very concerning information considering the descriptions made by detransitioners about the difficulty of finding a therapist willing or able to help them, and of finding alternative ways to deal with gender dysphoria after detransitioning (see Table 4).

The majority (84%) of the respondents reported having experienced both body and social gender dysphoria. Half of the sample (50%) later reported having decided to detransition due to the fact that their transition did not alleviate their gender dysphoria. Others (45%) reported having found alternative ways to deal with their gender dysphoria (see Figure 1). These results highlight the necessity to start looking into alternative solutions for treating gender dysphoria, in order to help those who did not find medical and/or social transition fulfilling.

In addition to that, 70% of the sample reported having realized that their gender dysphoria was related to other issues. Further research should be conducted in order to identify the ways in which other issues such as comorbid mental health conditions, trauma or internalized misogyny and homophobia possibly interact with gender dysphoria, and what can be done to alleviate them.

Furthermore, the high prevalence of autism spectrum condition (ASC) (20%) found in detransitioners in the current study, which is supported by Hailey (2017) findings (15%), also constitutes an interesting avenue for future research. Previous studies have provided evidence suggesting a co-occurrence of gender dysphoria and ASC (e.g., De Vries, Noens, Cohen-Kettenis, Van Berckelaer- Onnes, & Doreleijers, 2010; Glidden, Bouman, Jones, & Arcelus, 2016; VanderLaan et al., 2014; Van Der Miesen, Hurley, & De Vries, 2016; Zucker et al., 2017), which might explain the high number of detransitioners with an ASC diagnosis found in the current study.

In general, support given to detransitioners seems to be very poor at the moment, considering the fact that only 18% of the participants in the current study reported having received enough support during their detransition.

Based on the results of the current study, it appears that detransitioning is often accompanied by a break with LGBT+ communities. Only 13% of the participants reported having received support from an LGBT+ or trans-specific organization while detransitioning, compared to 51% while transitioning (see Figure 2). In addition to that, many respondents described experiences of outright rejection from LGBT+ spaces due to their decision to detransition (see Table 2). Looking at studies showing the positive role

of peer support and trans community connectedness on the mental health of its members (Johnson & Rogers, 2019; Pflum, Testa, Balsam, Goldblum, & Bongar, 2015; Sherman, Clark, Robinson, Noorani, & Poteat, 2020), it seems reasonable to suspect that this loss of support experienced by detransitioners must have serious implications on their psychological well-being.

Fortunately, the current study shows that detransitioners have access to other sources of support, online (groups, forums, social media) and in their social surroundings (family, partners and friends) (see Figure 2). Online groups and websites for detransitioners seem to be particularly important in light of the social needs expressed by the respondents of the current study. An overwhelming majority of respondents reported the need for hearing about other detransition stories (87%) and for getting in contact with other detransitioners (76%). Detransitioners need platforms and spaces where they can connect with each other and build a community. This point is best illustrated by the following account of one participant: “I found the peer support I received through other detransitioned women to be totally adequate and feel I benefited substantially from learning how to exist without institutional validation.”

Conclusion

The aim of the present research was to examine detransitioners’ needs and support. The four categories of needs (psychological, medical, legal and social) that were created for sake of clarity in the survey were a simplification of the real complexity of the experiences made by detransitioners and they have their limitations. Nonetheless, these categories enabled the current study to uncover the fact that most detransitioners could benefit from some form of counseling and in particular when it comes to psychological support on matters such as gender dysphoria, comorbid conditions, feelings of regret, social/physical changes and internalized homophobic or sexist prejudices. Medical support was also found to be needed by many, in order to address concerns related to stopping/changing hormone therapy, surgery/treatment complications and access to reversal interventions. Furthermore, the current study has shown that detransitioners need spaces to hear about other detransition stories and to exchange with each other.

Unfortunately, the support that detransitioners are receiving in order to fulfill these needs appears to be very poor at the moment. Participants described strong difficulties with medical and mental health systems, as well as experiences of outright rejection from the LGBT+ community. Many respondents have expressed the wish to find alternative treatments to deal with their gender dysphoria but reported that it was impossible to talk about it within LGBT+ spaces and in the medical sphere.

These accounts are concerning and they show the urgency to increase awareness and reduce hostility around the topic of detransition among health-care providers and members of the LGBT+ community in order to address the specific needs of detransitioners.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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Appendix.

Full Questionnaire

- (1) How old are you?
- (2) What country are you living in?
- (3) What sex were you assigned at birth?
 - Female
 - Male
 - Other:
- (4) How do you see yourself now? (Tick all that apply)
 - Woman
 - Man
 - Trans man
 - Trans woman
 - Female detransitioner
 - Male detransitioner
 - Non binary
 - Other:
- (5) Did you transition socially and/or medically and then stopped?
 - Yes, both
 - Only socially
 - No

- (6) Did you experience body dysphoria and/or social dysphoria? (Body dysphoria = strong desire to have sex characteristics of the opposite sex/rejection of your own sex; Social dysphoria = strong desire to be seen and treated as being of a different gender)
- Yes, both
 - Only body dysphoria
 - Only social dysphoria
 - No
- (7) Who helped you starting your social/medical transition? (Tick all that apply)
- A medical team specialized in transition
 - An LGBTQ+ organization
 - A trans-specific organization
 - A therapist/doctor
 - Online groups/forums/social media
 - Friends, partner(s) and family
 - Nobody
 - Other:
- (8) If you transitioned medically, how long were you in therapy before getting any hormones or surgeries? (in months; write 0 if none)
- (9) During your transition, did you undergo some of the following interventions/treatments? (Tick all that apply)
- Hormone blockers
 - Feminizing hormone treatment
 - Masculinizing hormone treatment
 - Gender affirming surgery(ies)
 - No
- (10) Do you feel like you were properly informed about the health implications of these treatments/interventions before undergoing them?
- Yes
 - Partly
 - No
 - I am not sure
- (11) What were the reasons that made you stop transitioning/detransition? (Tick all that apply)
- Health concerns
 - Change in political views
 - Transition did not help with my dysphoria
 - Lack of support from social surroundings
 - Discrimination
 - Financial concerns
 - Dysphoria resolved itself over time
 - Unhappy with the physical changes
 - Unhappy with the social changes
 - Comorbid mental health issues related to dysphoria solved
 - Realized that my gender dysphoria was related to other issues
 - Found alternatives to deal with dysphoria
 - Other:

(12) Were you diagnosed with or do you suspect having any of the following conditions?

	Diagnosed	Suspected	No
Attention Deficit (Hyperactive) Disorder			
Autism Spectrum Condition			
Anxiety Disorders			
Depressive Disorders			
Dissociative Identity Disorder			
Eating Disorders			
Obsessive Compulsive Disorder			
Polycystic Ovary Syndrome			
Post Traumatic Stress Disorder			
Personality Disorders			
Schizo-spectrum Disorder			

(13) If you transitioned socially, at what age did you start?

(14) If you transitioned medically, at what age did you start?

(15) At what age did you start detransitioning/stop transitioning?

(16) What are the medical needs that you had while detransitioning/stopping your transition?
(Tick all that apply)

- Receiving accurate information on stopping/changing hormonal treatment
- Receiving information and access to reversal surgeries/procedures
- Receiving help for complications related to surgeries or hormonal treatment
- None
- Other:

(17) What are the psychological needs that you had while detransitioning/stopping your transition? (Tick all that apply)

- Learning to cope with gender dysphoria; finding alternatives to medical transition
- Learning to cope with the new physical and/or social changes related to detransitioning
- Learning to cope with feelings of regret
- Learning to cope with internalized homophobia
- Working on comorbid mental issues related to gender dysphoria
- None
- Other:

(18) What are the legal needs that you had while detransitioning/stopping your transition?
(Tick all that apply)

- Changing back legal gender/sex marker and/or name
- Legal advice and support to take legal action over medical malpractice
- None
- Other:

(19) What are the social needs that you had while detransitioning/stopping your transition?
(Tick all that apply)

- Getting in contact with other detransitioners
- Receiving support to come out and deal with negative reactions
- Hearing about other detransition stories
- None
- Other:

(20) Is there any other need that you would like to mention?

(21) Which of these needs did you get support for?

	Full support	Partly	Not at all	Not needed
Medical needs				
Psychological needs				
Legal needs				
Social needs				

(22) From whom? (Tick all that apply)

- The medical team that helped me transition
- An LGBT+ organization
- A trans specific organization
- The therapist/doctor who supported me through my transition
- A new therapist/doctor
- Online groups/forums/social media
- Friends, partner(s) and family
- Nobody
- Other:

(23) Do you feel like you have received enough support throughout your detransition process overall?

- Yes
- No
- I don't know

(24) If you have any comment concerning the support/lack of support you received during your detransition, you can write it here.

DOC. 69-23

Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment



WHAT'S KNOWN ON THIS SUBJECT: Puberty suppression has rapidly become part of the standard clinical management protocols for transgender adolescents. To date, there is only limited evidence for the long-term effectiveness of this approach after gender reassignment (cross-sex hormones and surgery).



WHAT THIS STUDY ADDS: In young adulthood, gender dysphoria had resolved, psychological functioning had steadily improved, and well-being was comparable to same-age peers. The clinical protocol including puberty suppression had provided these formerly gender-dysphoric youth the opportunity to develop into well-functioning young adults.

abstract

BACKGROUND: In recent years, puberty suppression by means of gonadotropin-releasing hormone analogs has become accepted in clinical management of adolescents who have gender dysphoria (GD). The current study is the first longer-term longitudinal evaluation of the effectiveness of this approach.

METHODS: A total of 55 young transgender adults (22 transwomen and 33 transmen) who had received puberty suppression during adolescence were assessed 3 times: before the start of puberty suppression (mean age, 13.6 years), when cross-sex hormones were introduced (mean age, 16.7 years), and at least 1 year after gender reassignment surgery (mean age, 20.7 years). Psychological functioning (GD, body image, global functioning, depression, anxiety, emotional and behavioral problems) and objective (social and educational/professional functioning) and subjective (quality of life, satisfaction with life and happiness) well-being were investigated.

RESULTS: After gender reassignment, in young adulthood, the GD was alleviated and psychological functioning had steadily improved. Well-being was similar to or better than same-age young adults from the general population. Improvements in psychological functioning were positively correlated with postsurgical subjective well-being.

CONCLUSIONS: A clinical protocol of a multidisciplinary team with mental health professionals, physicians, and surgeons, including puberty suppression, followed by cross-sex hormones and gender reassignment surgery, provides gender dysphoric youth who seek gender reassignment from early puberty on, the opportunity to develop into well-functioning young adults. *Pediatrics* 2014;134:696–704

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KEY WORDS

gender dysphoria, transgenderism, adolescents, psychological functioning, puberty suppression, longitudinal outcomes

ABBREVIATIONS

ABCL—Adult Behavior Checklist

ASR—Adult Self-Report

BDI—Beck Depression Inventory

BIS—Body Image Scale

CBCL—Child Behavior Checklist

CGAS—Children's Global Assessment Scale

CSH—cross-sex hormones

GD—gender dysphoria

GnRHa—gonadotropin-releasing hormone analogs

GRS—gender reassignment surgery

SHS—Subjective Happiness Scale

STAI—Spielberger's Trait Anxiety Scale

SWLS—Satisfaction With Life Scale

TPI—Spielberger's Trait Anger Scale

UGDS—Utrecht Gender Dysphoria Scale

YSR—Youth Self-Report

Dr de Vries conceptualized the study, clinically assessed the participants, drafted the initial manuscript, and reviewed and revised the manuscript; Dr McGuire conceptualized the study, planned and carried out the analyses, assisted in drafting the initial manuscript, and reviewed and revised the manuscript; Dr Steensma conceptualized the study, coordinated and supervised data collection, and reviewed and revised the manuscript; Dr Wagenaar coordinated and invited participants for assessments and reviewed and revised the manuscript; Drs Doreleijers and Cohen-Kettenis conceptualized the study and reviewed and revised the manuscript; and all authors approved the final manuscript as submitted.

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(Continued on last page)

Transgender adolescents experience an incongruence between their assigned gender and their experienced gender and may meet the Diagnostic and Statistical Manual of Mental Disorders 5 criteria for gender dysphoria (GD).¹ Fifteen years ago, pubertal delay was introduced as an aid in the treatment of a gender dysphoric adolescent.² Although not without debate, blocking pubertal development has rapidly become more widely available^{3–7} and is now part of the clinical management guidelines for GD.^{8–12}

Gonadotropin-releasing hormone analogs (GnRHa) are a putatively fully reversible¹³ medical intervention intended to relieve distress that gender dysphoric adolescents experience when their secondary sex characteristics develop. A protocol designed by Cohen-Kettenis and Delemarre-van de Waal¹⁴ (sometimes referred to as “the Dutch model”)^{4,7} considers adolescents, after a comprehensive psychological evaluation with many sessions over a longer period of time, eligible for puberty suppression, cross-sex hormones (CSH), and gender reassignment surgery (GRS) at the respective ages of 12, 16, and 18 years when there is a history of GD; no psychosocial problems interfering with assessment or treatment, for example, treatment might be postponed because of continuous moving from 1 institution to another or repeated psychiatric crises; adequate family or other support; and good comprehension of the impact of medical interventions.¹² Puberty suppression is only started after the adolescent actually enters the first stages of puberty (Tanner stages 2–3), because although in most prepubertal children GD will desist, onset of puberty serves as a critical diagnostic stage, because the likelihood that GD will persist into adulthood is much higher in adolescence than in the case of childhood GD.^{15,16}

Despite the apparent usefulness of puberty suppression, there is only limited evidence available about the effective-

ness of this approach. In the first cohort of adolescents who received GnRHa, we demonstrated an improvement in several domains of psychological functioning after, on average, 2 years of puberty suppression while GD remained unchanged.¹⁶ The current study is a longer-term evaluation of the same cohort, on average, 6 years after their initial presentation at the gender identity clinic. This time, we were not only interested in psychological functioning and GD, but added as important outcome measures objective and subjective well-being (often referred to as “quality of life”), that is, the individuals’ social life circumstances and their perceptions of satisfaction with life and happiness.^{17–19} After all, treatment cannot be considered a success if GD resolves without young adults reporting they are healthy, content with their lives, and in a position to make a good start with their adult professional and personal lives.²⁰ Because various studies show that transgender youth may present with psychosocial problems,^{21,22} a clinical approach that includes both medical (puberty suppression) and mental health support (regular sessions, treatment when necessary, see Cohen-Kettenis et al¹²) aims to improve long-term well-being in all respects.

In the present longitudinal study, 3 primary research questions are addressed. Do gender dysphoric youth improve over time with medical intervention consisting of GnRHa, CSH, and GRS? After gender reassignment, how satisfied are young adults with their treatment and how do they evaluate their objective and subjective well-being? Finally, do young people who report relatively greater gains in psychological functioning also report a higher subjective well-being after gender reassignment?

METHODS

Participants and Procedure

Participants included 55 young adults (22 transwomen [natal males who

have a female gender identity] and 33 transmen [natal females who have a male gender identity]) of the first cohort of 70 adolescents who had GD who were prescribed puberty suppression at the Center of Expertise on Gender Dysphoria of the VU University Medical Center and continued with GRS between 2004 and 2011. These adolescents belonged to a group of 196 consecutively referred adolescents between 2000 and 2008, of whom 140 had been considered eligible for medical intervention and 111 were prescribed puberty suppression (see de Vries et al¹⁶). The young adults were invited between 2008 and 2012, when they were at least 1 year past their GRS (vaginoplasty for transwomen, mastectomy and hysterectomy with ovariectomy for transmen; many transmen chose not to undergo a phalloplasty or were on a long waiting list). Nonparticipation ($n = 15$, 11 transwomen and 4 transmen) was attributable to not being 1 year postsurgical yet ($n = 6$), refusal ($n = 2$), failure to return questionnaires ($n = 2$), being medically not eligible (eg, uncontrolled diabetes, morbid obesity) for surgery ($n = 3$), dropping out of care ($n = 1$), and 1 transfemale died after her vaginoplasty owing to a postsurgical necrotizing fasciitis. Between the 55 participants and the 15 nonparticipating individuals, Student’s t tests revealed no significant differences on any of the pretreatment variables. A similar lack of differences was found between the 40 participants who had complete data and the 15 who were missing some data.

Participants were assessed 3 times: pre-treatment (T0, at intake), during treatment (T1, at initiation of CSH), and post-treatment (T2, 1 year after GRS). See Table 1 for age at the different time points. The VU University Medical Center medical ethics committee approved the study, and all participants gave informed consent.

TABLE 1 Age at Different Treatment Milestones and Intelligence by Gender

Variable	All Participants ^a (N = 55)		Transwomen (Natal Males) (N = 22)	Transmen (Natal Females) (N = 33)
Age, y	Mean (SD)	Range	Mean (SD)	Mean (SD)
At assessment PreT	13.6 (1.9)	11.1–17.0	13.6 (1.8)	13.7 (2.0)
At start of GnRHa	14.8 (1.8)	11.5–18.5	14.8 (2.0)	14.9 (1.9)
At start of CSH	16.7 (1.1)	13.9–19.0	16.5 (1.3)	16.8 (1.0)
At GRS	19.2 (0.9)	18.0–21.3	19.6 (0.9)	19.0 (0.8)
At assessment PostT	20.7 (1.0)	19.5–22.8	21.0 (1.1)	20.5 (0.8)
Full-scale intelligence ^b	99.0 (14.3)	70–128	97.8 (14.2)	100.4 (14.3)

PostT, post-treatment; PreT, pre-treatment.

^a Comparisons between those who had complete data (n = 40) and those who had missing data on the CBCL/ABCL (n = 15) reveal no significant differences between the groups in age at any point in the study or in natal sex.

^b WISC-R, the WISC-III, or the WAIS-III at first assessment, depending on age and time.^{45–47}

Measures

Time was the predominate independent variable. Other demographic characteristics were incorporated in some models, including, age, natal sex, Full Scale Intelligence, and parent marital status; where significantly different they are reported.

Gender Dysphoria/Body Image

There was 1 indicator measuring GD (Utrecht Gender Dysphoria Scale [UGDS]) and 3 indicators measuring body image (Body Image Scale [BIS] with primary, secondary, and neutral subscales). Higher UGDS (12 items, 1–5 range, total score ranging from 12–60) total scores indicate higher levels of GD, for example, “I feel a continuous desire to be treated as a man/woman.”²³ There are separate versions of the UGDS for males and females with mostly different items, permitting no gender difference analyses. BIS (30 items, 1–5 range) higher scores indicate more dissatisfaction with primary sex characteristics (important gender-defining body characteristics, eg, genitals, breasts), secondary sex characteristics (less obvious gender-defining features, eg, hips, body hair), and neutral (hormonally unresponsive) body characteristics (eg, face, height).²⁴ The male and the female BIS are identical except for the sexual body parts. The UGDS and the BIS of the natal gender were administered at T0 and T1. At T1, we chose the UGDS of the assigned gender, because no physical changes had occurred yet and some were still

treated as their assigned gender. This way, however, decreased GD caused by social transitioning was not measured. At T2 young adults filled out the versions of their affirmed gender.

Psychological Functioning

There were 10 indicators assessing psychological functioning. To assess global functioning, the Children’s Global Assessment Scale (CGAS) was used.²⁵ The Beck Depression Inventory (BDI; 21 items, 0–3 range) indicates presence and severity of depressive symptoms.²⁶ Spielberger’s Trait Anger (TPI) and Spielberger’s Trait Anxiety (STAI; 10 and 20 items, respectively, 1–4 range) scales of the State-Trait Personality Inventory were administered to assess the tendency to respond with anxiety or anger, respectively, to a threatening or annoying situation.^{27,28}

Behavioral and emotional problems were assessed by the total, internalizing, and externalizing T scores as well as clinical range scores for these 3 indices (T score >63) of the Child/Adult Behavior Checklist (CBCL at T0 and T1, ABCL at T2), the Youth/Adult Self-Report (YSR at T0 and T1, ASR at T2).^{29–31} Items referring to GD in the CBCL/YSR and ABCL/ASR were scored as 0 (for more explanation, see Cohen-Kettenis et al³²).

Objective and Subjective Well-Being (T2 Only)

A self-constructed questionnaire was used to ask the young adults about their current life circumstances, such

as living conditions, school and employment, and social support (objective well-being), and satisfaction with treatment (subjective well-being). Three instruments further assessed subjective well-being. To measure quality of life, the WHOQOL-BREF (quality of life measure developed by the World Health Organization) was administered (24 items, 4 domains: Physical Health, Psychological Health, Social Relationships, and Environment, 1–5 range with higher scores indicating better quality of life).¹⁷ The Satisfaction With Life Scale (SWLS, 5 items, 5–35 range, 20 being neutral) was used to assess life satisfaction.¹⁸ Higher scores on the Subjective Happiness Scale (SHS, 4 items, 7-point Likert scale, average score 1–7) reflect greater happiness.¹⁹

Data Analyses

General Linear Models examined the repeated measures with an analysis of variance-based model, incorporating continuous and categorical predictors, and correcting for the unbalanced cell sizes. Linear and quadratic effects of the 14 indicators across 3 time points, with time as the within-subjects factor, and sex as a between-subjects factor in a second set of analyses are reported in Tables 2 and 3 and Fig 1. A linear effect signifies an overall change across T0 to T2. A quadratic effect signifies that the change was not continuous, such as when an indicator does not improve from T0 to T1 but improves from T1 to T2. It is possible to have both a significant linear and quadratic effect on the same

TABLE 2 Gender Dysphoria and Body Image of Adolescents at Intake (T0), While on Puberty Suppression (T1), and After Gender Reassignment (T2)

	N ^a	T0	T1	T2	T0–T2	Time	Time × Sex
		Mean (SD)	Mean (SD)	Mean (SD)	<i>t</i> test <i>P</i>	Linear Effect Quadratic Effect <i>P</i>	Linear Effect Quadratic Effect <i>P</i>
UGDS	33	53.51 (8.29)	54.39 (7.70)	15.81 (2.78)	<.001		
MtF	11	47.07 (11.05)	48.95 (10.80)	17.27 (2.57)	<.001	<.001 <.001	n/a
FtM	22	56.74 (3.74)	57.11 (3.40)	15.08 (2.64)	<.001	<.001 <.001	n/a
Body Image (BIS)							
Primary sex characteristics	45	4.13 (0.59)	4.05 (0.60)	2.59 (0.82)	<.001	<.001 <.001	.01 .45
MtF	17	4.03 (0.68)	3.82 (0.56)	2.07 (0.74)	<.001		
FtM	28	4.18 (0.53)	4.13 (0.60)	2.89 (0.71)	<.001		
Secondary sex characteristics	45	2.73 (0.72)	2.86 (0.67)	2.27 (0.56)	<.001	<.001 <.001	.10 <.001
MtF	17	2.63 (0.60)	2.34 (0.68)	1.93 (0.63)	<.001		
FtM	28	2.80 (0.72)	3.18 (0.43)	2.48 (0.40)	.05		
Neutral body characteristics	45	2.35 (0.68)	2.49 (0.53)	2.23 (0.49)	.29	.29 .01	.007 .01
MtF	17	2.57 (0.70)	2.29 (0.50)	2.09 (0.56)	.014		
FtM	28	2.21 (0.64)	2.61 (0.52)	2.32 (0.44)	.40		

FtM, female to male transgender; MtF, male to female transgender; n/a, not applicable.

^a Participants who had complete data at all 3 waves were included. Some assessments were added to the study later, yielding fewer total participants for those scales.

indicator. Other potential between-subjects factors (age, total IQ, parental marital status) were examined but excluded owing to a lack of relationship with the 14 indicators at T0. The 1 exception, age predicting secondary sex characteristics, is described below in the findings. We compared T2 sample means to population norms for subjective well-being using 1-sample *t* tests from previously published validation studies. Finally, we examined T2 subjective well-being correlations with residual change scores from T0 to T2 on the 14 indicators (an indicator of who improved relatively more or less over time).

All measures used were self-reported, except the CGAS (attending clinician) and the CBCL/ASR (parents). Each participant was given all measures at each of 3 assessments. Numbers varied across indicators owing to the later inclusion of the YSR, CGAS, BDI, TPI, and STAI, yielding 8 persons who had missing data at T0 and a clinician error yielding missing data at T1 for 10 participants on the UGDS. Dutch versions were used (see de Vries et al¹⁶).

RESULTS

Gender Dysphoria and Body Satisfaction

Figure 1 and Table 2 show that GD and body image difficulties persisted through puberty suppression (at T0 and T1) and remitted after the administration of CSH and GRS (at T2) (significant linear effects in 3 of 4 indicators, and significant quadratic effects in all indicators). Time by sex interactions revealed that transwomen reported more satisfaction over time with primary sex characteristics than transmen and a continuous improvement in satisfaction with secondary and neutral sex characteristics. Transmen reported more dissatisfaction with secondary and neutral sex characteristics at T1 than T0, but improvement in both from T1 to T2. Age was a significant covariate with secondary sex characteristics (the only significant demographic covariate with any outcome indicator in the study), indicating that older individuals were more dissatisfied at T0, but the age gap in body satisfaction narrowed over time ($F(1, 42) = 8.18; P < .01$).

Psychological Functioning

As presented in Table 3, significant linear effects showed improvement over time in global functioning (CGAS), CBCL/ABCL total, internalizing and externalizing *T* scores, and YSR/ASR total and internalizing *T* scores. Quadratic effects revealed decreases from T0 to T1 followed by increases from T1 to T2 in depression and YSR/ASR internalizing *T* scores. Quadratic trends revealed decreases from T0 to T1, followed by increases from T1 to T2 in depression and YSR/ASR internalizing *T* scores. For all CBCL/ABCL and YSR/ASR indicators except YSR/ASR externalizing, the percentage in the clinical range dropped significantly (McNemar's test, *P* value <0.05) from T0 to T1, from T0 to T2, or from T1 to T2.

Over time, transmen showed reduced anger, anxiety, and CBCL/ABCL externalizing *T* scores, whereas transwomen showed stable or slightly more symptomatology on these measures. Transwomen improved in CBCL/ABCL total *T* scores in a quadratic fashion (all the improvement between T1 and T2),

TABLE 3 Psychological Functioning of Adolescents at Intake (T0), While on Puberty Suppression (T1), and After Gender Reassignment (T2)

	N ^a	T0	T1	T2	T0–T2	Time		Time × Sex	
						<i>t</i> test	Linear Effect Quadratic Effect	Linear Effect Quadratic Effect	
		Mean (SD)	Mean (SD)	Mean (SD)	<i>P</i>				
Global functioning (CGAS)	32	71.13 (10.46)	74.81 (9.86)	79.94 (11.56)	<.001				
MtF	15	74.33 (7.53)	78.20 (9.56)	82.40 (8.28)	<.001				
FtM	17	67.65 (11.87)	70.65 (9.89)	76.29 (14.48)	.02				
Depression (BDI)	32	7.89 (7.52)	4.10 (6.17)	5.44 (8.40)	.21		.23		.66
							.04		.49
MtF	12	4.73 (4.20)	2.25 (3.54)	3.38 (4.40)	.12				
FtM	20	10.09 (8.34)	5.05 (7.08)	6.95 (9.83)	.32				
Anger (TPI)	32	17.55 (5.72)	17.22 (5.61)	16.01 (5.28)	.20		.15		.04
							.52		.12
MtF	12	14.17 (3.01)	14.00 (3.36)	5.58 (3.92)	.18				
FtM	20	19.55 (5.96)	19.25 (5.69)	16.56 (6.06)	.05				
Anxiety (STAI)	32	39.57 (10.53)	37.52 (9.87)	37.61 (10.39)	.45		.42		.05
							.47		.52
MtF	12	31.87 (7.42)	31.71 (8.36)	35.83 (10.22)	.14				
FtM	20	44.41 (9.06)	41.59 (9.03)	39.20 (10.53)	.12				
CBCL–ABCL									
Total <i>T</i> score	40	60.20 (12.66)	54.70 (11.58)	48.10 (9.30)	<.001		<.001		.25
% Clinical		38 _x	20 _y	5 _y			.68		.03
MtF	15	57.40 (12.76)	49.67 (12.29)	48.13 (12.58)	.002				
FtM	25	61.88 (12.56)	57.72 (10.23)	48.08 (6.95)	<.001				
Int <i>T</i> score	40	60.83 (12.36)	54.42 (10.58)	50.45 (10.04)	<.001		<.001		.91
% Clinical		30 _x	12.5 _y	10 _y			.42		.33
MtF	15	59.40 (10.03)	50.93 (11.15)	48.73 (12.61)	<.001				
FtM	25	61.68 (13.70)	56.52 (9.86)	51.48 (8.25)	<.001				
Ext <i>T</i> score	40	57.85 (13.73)	53.85 (12.77)	47.85 (8.59)	<.001		<.001		.19
% Clinical		40 _x	25 _x	2.5 _y			.43		.12
MtF	15	52.53 (14.11)	47.87 (12.07)	46.33 (10.95)	.10				
FtM	25	61.04 (12.71)	57.44 (12.01)	48.76 (6.89)	<.001				
YSR–ASR									
Total <i>T</i> score	43	54.72 (12.08)	49.16 (11.16)	48.53 (9.46)	.005		.005		.28
% Clinical		30 _x	14 _{xy}	7 _y			.07		.75
MtF	17	50.65 (12.19)	45.94 (12.24)	47.24 (12.28)	.28				
FtM	26	57.38 (11.47)	51.27 (10.08)	49.38 (7.21)	.01				
Int <i>T</i> score	43	55.47 (13.08)	48.65 (12.33)	50.07 (11.15)	.03		.03		.87
% Clinical		30 _x	9.3 _y	11.6 _{xy}			.008		.73
MtF	17	54.00 (12.31)	47.59 (14.26)	48.12 (12.54)	.04				
FtM	26	56.42 (13.86)	49.35 (11.13)	51.35 (10.19)	.17				
Ext <i>T</i> score	43	52.77 (12.47)	49.44 (9.59)	49.44 (9.37)	.14		.14		.005
% Clinical		21 _x	11.6 _x	7 _x			.09		.14
MtF	17	46.00 (11.58)	44.71 (9.53)	50.24 (11.18)	.17				
FtM	26	57.16 (11.14)	52.54 (8.43)	48.92 (8.18)	.006				

FtM, female to male transgender; MtF, male to female transgender.

_{xy} Percent clinical range, shared subscripts indicate no significant difference in values. In no case was an increase in percent in the clinical range significant from 1 time point to any other time point, indicating an overall decline or stability of clinical symptoms over time.

^a Participants who had complete data at all 3 waves were included. Some assessments were added to the study later, yielding fewer total participants for those scales.

whereas transmen improved steadily across the 3 time points (linear effect only).

Objective Well-Being

At T2, the participants were vocationally similar to the Dutch population except they were slightly more likely to live with parents (67% vs 63%), and more likely,

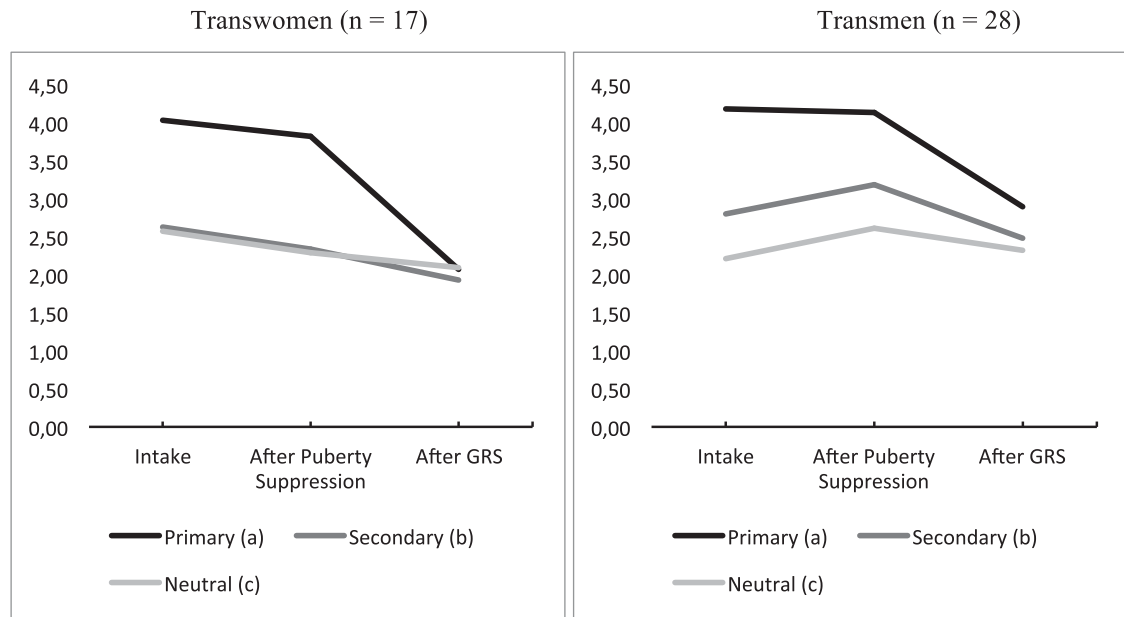
when studying, to be pursuing higher education (58% vs 31%).³³

Families were supportive of the transitioning process: 95% of mothers, 80% of fathers, and 87% of siblings. Most (79%) young adults reported having 3 or more friends, were satisfied with their male (82%) and female peers (88%), and almost all (95%) had received support

from friends regarding their gender reassignment. After their GRS, many participants (89%) reported having been never or seldom called names or harassed. The majority (71%) had experienced social transitioning as easy.

Subjective Well-Being

None of the participants reported regret during puberty suppression, GSH



Eta Squared for Linear and Quadratic Effects

- (a) Primary sex characteristics
Time: .79 ($P < .001$), .66 ($P < .001$),
Time \times sex: .14 ($P = .01$), .01 ($P = .45$),
- (b) Secondary sex characteristics
Time: .31 ($P < .001$), .30 ($P < .001$),
Time \times sex: .06 ($P = .10$), .22 ($P < .001$)
- (c) Neutral body characteristics
Time: .07 ($P < .001$), .09 ($P = .29$)
Time \times sex: .16 ($P = .007$), .15 ($P = .01$)

FIGURE 1

BIS²³ for transwomen and transmen at T0 (pretreatment, at intake), T1 (during treatment, at initiation of cross-gender hormones), and T2 (post-treatment, 1 year after GRS).

treatment, or after GRS. Satisfaction with appearance in the new gender was high, and at T2 no one reported being treated by others as someone of their assigned gender. All young adults reported they were very or fairly satisfied with their surgeries.

Mean scores on WHOQOL-BREF, the SWLS, and the SHS are presented in Table 4, together with scores from large validation and reliability studies of these measures,^{17,19,34} revealing similar scores in all areas except WHOQOL-Environment subdomain, which was higher for the participants than the norm. There were some differences across gender; transwomen scored higher than transmen on the SWLS (mean = 27.7; SD = 5.0 vs mean = 23.2; SD = 6.0; t (52)

= 2.82; $P < .01$) and on the psychological subdomain of the WHOQOL (mean = 15.77; SD = 2.0 vs mean = 13.92; SD = 2.5; t (53) = 2.95; $P < .01$).

Correlations With Residual Change Scores

The residual change scores of secondary sex characteristics, global functioning, depression, anger, anxiety, and YSR total, internalizing and externalizing from T0 to T2, were significantly correlated with the 6 T2 quality of life indicators. Most correlation coefficients were within the moderate to large magnitude (eg, 0.30–0.60), except depression, which was highly correlated (0.60–0.80) (see Table 5).

DISCUSSION

Results of this first long-term evaluation of puberty suppression among transgender adolescents after CSH treatment and GRS indicate that not only was GD resolved, but well-being was in many respects comparable to peers.

The effectiveness of CSH and GRS for the treatment of GD in adolescents is in line with findings in adult transsexuals.^{35,36} Whereas some studies show that poor surgical results are a determinant of postoperative psychopathology and of dissatisfaction and regret,^{37,38} all young adults in this study were generally satisfied with their physical appearance and none regretted treatment. Puberty suppression had caused their bodies to

TABLE 4 Subjective Well-Being: Quality of Life, Satisfaction With Life, and Subjective Happiness Mean Scores With Scores From Validation Studies

	<i>N</i>	Mean (SD)	Range	Validation Studies Scores Mean (SD)	Comparison <i>P</i>
WHOQOL ^a Physical	55	15.22 (2.49)	8.6–20.0	15.0 (2.9) ^b	.56
WHOQOL Psychological	55	14.66 (2.44)	6.67–20.0	14.3 (2.8) ^b	.24
WHOQOL Social Relations	55	14.91 (2.35)	9.3–20.00	14.5 (3.4) ^b	.18
WHOQOL Environment	55	15.47 (2.06)	10.5–20.00	13.7 (2.6) ^b	<.001
SWLS	54	24.98 (6.0)	9.0–35.0	26.18 (5.7) ^c	.16
SHS	54	4.73 (0.77)	2.75–6.0	4.89 (1.1) ^d	.17

^a WHOQOL, Bref, Skevington et al.¹⁶

^b International field trial, ages 21 to 30 years, Skevington et al.¹⁶

^c Dutch young adults, Arindell et al.³³

^d US Public College Students, Lyubomirsky.¹⁸

not (further) develop contrary to their experienced gender.

Psychological functioning improved steadily over time, resulting in rates of clinical problems that are indistinguishable from general population samples (eg, percent in the clinical range dropped from 30% to 7% on the YSR/ASR³⁰) and quality of life, satisfaction with life, and subjective happiness comparable to same-age peers.^{17,19,34} Apparently the clinical protocol of a multidisciplinary team with mental health professionals, physicians, and surgeons gave these formerly gender dysphoric youth the opportunity to develop into well-functioning young adults. These individuals, of whom an even higher percentage than the general population were pursuing higher education, seem different from the

transgender youth in community samples with high rates of mental health disorders, suicidality and self-harming behavior, and poor access to health services.^{21,22,39,40}

In this study, young adults who experienced relatively greater improvements in psychological functioning were more likely to also report higher levels of subjective postsurgical well-being. This finding suggests value to the protocol that involves monitoring the adolescents' functioning, physically and psychologically, over many years, and providing more support whenever necessary.

This clinic-referred sample perceived the Environmental subdomain (with items like "access to health and social care" and "physical safety and secu-

rity") of the WHOQOL-BREF as even better than the Dutch standardization sample.¹⁷ Whereas in some other contexts transgender youth may experience gender-related abuse and victimization,^{22,41,42} the positive results may also be attributable to supportive parents, open-minded peers, and the social and financial support (treatment is covered by health insurance) that gender dysphoric individuals can receive in the Netherlands.

Both genders benefitted from the clinical approach, although transwomen showed more improvement in body image satisfaction (secondary sex characteristics) and in psychological functioning (anger and anxiety). None of the transmen in this study had yet had a phalloplasty because of waiting lists or

TABLE 5 Correlations Between Residual Change in Psychological Functioning Over Time and Young Adult Subjective Well-Being

	WHOQOL BREF					
	Physical	Psychological	Social	Environment	SWLS	SHS
Gender dysphoria (UGDS)	0.01 (.97)	0.05 (.75)	−0.09 (.57)	−0.02 (.89)	0.06 (.71)	0.30 (.04)
Body image subscales (BIS)						
Primary sex characteristics	−0.22 (.14)	−0.25 (.09)	−0.35 (.02)	−0.04 (.78)	−0.22 (.14)	−0.21 (.17)
Secondary sex characteristics	−0.39 (.006)	−0.45 (<.001)	−0.47 (<.001)	−0.34 (.02)	−0.35 (.02)	−0.26 (.08)
Neutral body characteristics	−0.21 (.16)	−0.27 (.07)	−0.15 (.32)	−0.28 (.06)	−0.26 (.08)	−0.16 (.28)
Psychological functioning						
Global functioning (CGAS)	0.60 (<.001)	0.52 (.002)	0.52 (.002)	0.27 (.14)	0.58 (<.001)	0.50 (.004)
Depression (BDI)	−0.76 (<.001)	−0.72 (<.001)	−0.51 (.002)	−0.49 (.003)	−0.61 (<.001)	−0.77 (<.001)
Trait anger (TPI)	−0.37 (.03)	−0.18 (.31)	−0.22 (.20)	−0.29 (.09)	−0.33 (.07)	−0.35 (.05)
Trait anxiety (STAI)	−0.58 (<.001)	−0.64 (<.001)	−0.38 (.03)	−0.44 (.01)	−0.49 (.004)	−0.57 (<.001)
CBCL–ABCL						
Total <i>T</i> score	−0.20 (.20)	−0.12 (.45)	−0.07 (.65)	−0.14 (.35)	−0.32 (.03)	−0.16 (.29)
Internalizing <i>T</i> score	−0.29 (.06)	−0.29 (.06)	−0.23 (.14)	−0.12 (.44)	−0.48 (<.001)	−0.36 (.02)
Externalizing <i>T</i> score	−0.13 (.40)	−0.05 (.75)	0.16 (.29)	−0.20 (.19)	−0.15 (.36)	0.00 (.99)
Youth Self Report (YSR–ASR)						
Total <i>T</i> score	−0.53 (<.001)	−0.45 (.002)	−0.33 (.03)	−0.42 (.005)	−0.52 (<.001)	−0.55 (<.001)
Internalizing <i>T</i> score	−0.62 (<.001)	−0.61 (<.001)	−0.47 (<.001)	−0.40 (.007)	−0.66 (<.001)	−0.60 (<.001)
Externalizing <i>T</i> score	−0.23 (.13)	−0.10 (.53)	−0.07 (.67)	−0.37 (.02)	−0.22 (.15)	−0.35 (.02)

P values are in parentheses.

a desire for improved surgery techniques. This finding warrants further study of the specific concerns of young transmen.

Despite promising findings, there were various limitations. First, the study sample was small and came from only 1 clinic. Second, this study did not focus on physical side effects of treatment. Publications on physical parameters of the same cohort of adolescents are submitted or in preparation. A concurring finding exists in the 22-year follow-up of the well-functioning first case now at age 35 years who has no clinical signs of a negative impact of earlier puberty suppression on brain development, metabolic and endocrine parameters, or bone mineral density.⁴³ Third, despite the absence of pretreatment differences on measured indicators, a selection bias could exist between adolescents of the original cohort that participated in this study compared with nonparticipants.

Age criteria for puberty suppression and CSH are under debate, although they worked well for adolescents in the current study. Especially in natal females, puberty will often start before the age of 12 years. Despite the fact that developing evidence suggests that cognitive and affective cross-gender identification, social role transition, and age at assessment are related to persistence of childhood GD into adolescence, predicting individual persistence at a young age will always remain difficult.⁴⁴ The age criterion of 16 years for the start of CSH may be problematic especially for transwomen, as growth in height continues as long as cross-sex steroids are not provided (causing the growth plates to close). Therefore, psychological maturity and the capacity to give full informed consent may surface as the required criteria for puberty suppression and CSH⁴⁵ in cases that meet other eligibility criteria.

CONCLUSIONS

Results of this study provide first evidence that, after CSH and GRS, a treatment protocol including puberty suppression leads to improved psychological functioning of transgender adolescents. While enabling them to make important age-appropriate developmental transitions, it contributes to a satisfactory objective and subjective well-being in young adulthood. Clinicians should realize that it is not only early medical intervention that determines this success, but also a comprehensive multidisciplinary approach that attends to the adolescents' GD as well as their further well-being and a supportive environment.

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Young Adult Psychological Outcome After Puberty Suppression and Gender Reassignment

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POLICY STATEMENT Organizational Principles to Guide and Define the Child Health Care System
and/or Improve the Health of all Children

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DEDICATED TO THE HEALTH OF ALL CHILDREN™

Ensuring Comprehensive Care and Support for Transgender and Gender-Diverse Children and Adolescents

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As a traditionally underserved population that faces numerous health disparities, youth who identify as transgender and gender diverse (TGD) and their families are increasingly presenting to pediatric providers for education, care, and referrals. The need for more formal training, standardized treatment, and research on safety and medical outcomes often leaves providers feeling ill equipped to support and care for patients that identify as TGD and families. In this policy statement, we review relevant concepts and challenges and provide suggestions for pediatric providers that are focused on promoting the health and positive development of youth that identify as TGD while eliminating discrimination and stigma.

abstract

FREE

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Dr Rafferty conceptualized the statement, drafted the initial manuscript, reviewed and revised the manuscript, approved the final manuscript as submitted, and agrees to be accountable for all aspects of the work.

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INTRODUCTION

In its dedication to the health of all children, the American Academy of Pediatrics (AAP) strives to improve health care access and eliminate disparities for children and teenagers who identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ) of their sexual or gender identity.^{1,2} Despite some advances in public awareness and legal protections, youth who identify as LGBTQ continue to face disparities that stem from multiple sources, including inequitable laws and policies, societal discrimination, and a lack of access to quality health care, including mental health care. Such challenges are often more intense for youth who do not conform to social expectations and norms regarding gender. Pediatric providers are increasingly encountering such youth and their families, who seek medical advice and interventions, yet they may lack the formal training to care for youth that identify as transgender and gender diverse (TGD) and their families.³

This policy statement is focused specifically on children and youth that identify as TGD rather than the larger LGBTQ population, providing brief, relevant background on the basis of current available research

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TABLE 1 Relevant Terms and Definitions Related to Gender Care

Term	Definition
Sex	An assignment that is made at birth, usually male or female, typically on the basis of external genital anatomy but sometimes on the basis of internal gonads, chromosomes, or hormone levels
Gender identity	A person's deep internal sense of being female, male, a combination of both, somewhere in between, or neither; resulting from a multifaceted interaction of biological traits, environmental factors, self-understanding, and cultural expectations
Gender expression	The external way a person expresses their gender, such as with clothing, hair, mannerisms, activities, or social roles
Gender perception	The way others interpret a person's gender expression
Gender diverse	A term that is used to describe people with gender behaviors, appearances, or identities that are incongruent with those culturally assigned to their birth sex; gender-diverse individuals may refer to themselves with many different terms, such as transgender, nonbinary, genderqueer; ⁷ gender fluid, gender creative, gender independent, or noncisgender. "Gender diverse" is used to acknowledge and include the vast diversity of gender identities that exists. It replaces the former term, "gender nonconforming," which has a negative and exclusionary connotation.
Transgender	A subset of gender-diverse youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time; the term "transgender" also encompasses many other labels individuals may use to refer to themselves.
Cisgender	A term that is used to describe a person who identifies and expresses a gender that is consistent with the culturally defined norms of the sex they were assigned at birth
Agender	A term that is used to describe a person who does not identify as having a particular gender
Affirmed gender	When a person's true gender identity, or concern about their gender identity, is communicated to and validated from others as authentic
MTF; affirmed female; trans female	Terms that are used to describe individuals who were assigned male sex at birth but who have a gender identity and/or expression that is asserted to be more feminine
FTM; affirmed male; trans male	Terms that are used to describe individuals who were assigned female sex at birth but who have a gender identity and/or expression that is asserted to be more masculine
Gender dysphoria	A clinical symptom that is characterized by a sense of alienation to some or all of the physical characteristics or social roles of one's assigned gender; also, gender dysphoria is the psychiatric diagnosis in the <i>DSM-5</i> , which has focus on the distress that stems from the incongruence between one's expressed or experienced (affirmed) gender and the gender assigned at birth.
Gender identity disorder	A psychiatric diagnosis defined previously in the <i>DSM-IV</i> (changed to "gender dysphoria" in the <i>DSM-5</i>); the primary criteria include a strong, persistent cross-sex identification and significant distress and social impairment. This diagnosis is no longer appropriate for use and may lead to stigma, but the term may be found in older research.
Sexual orientation	A person's sexual identity in relation to the gender(s) to which they are attracted; sexual orientation and gender identity develop separately.

This list is not intended to be all inclusive. The pronouns "they" and "their" are used intentionally to be inclusive rather than the binary pronouns "he" and "she" and "his" and "her." Adapted from Bonifacio HJ, Rosenthal SM. Gender variance and dysphoria in children and adolescents. *Pediatr Clin North Am*. 2015;62(4):1001–1016. Adapted from Vance SR Jr, Ehrensaft D, Rosenthal SM. Psychological and medical care of gender nonconforming youth. *Pediatrics*. 2014;134(6):1184–1192. *DSM-5, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*; *DSM-IV, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; FTM, female to male; MTF, male to female.

and expert opinion from clinical and research leaders, which will serve as the basis for recommendations. It is not a comprehensive review of clinical approaches and nuances to pediatric care for children and youth that identify as TGD. Professional understanding of youth that identify as TGD is a rapidly evolving clinical field in which research on appropriate clinical management is limited by insufficient funding.^{3,4}

DEFINITIONS

To clarify recommendations and discussions in this policy statement, some definitions are provided. However, brief descriptions of human behavior or identities may not capture nuance in this evolving field.

"Sex," or "natal gender," is a label, generally "male" or "female," that is typically assigned at birth on the basis of genetic and anatomic characteristics, such as genital anatomy, chromosomes, and sex hormone levels. Meanwhile, "gender identity" is one's internal sense of who one is, which results from a multifaceted interaction of biological traits, developmental influences, and environmental conditions. It may be male, female, somewhere in between, a combination of both, or neither (ie, not conforming to a binary conceptualization of gender). Self-recognition of gender identity develops over time, much the same way as a child's physical body does. For some people, gender identity can be fluid, shifting in different contexts. "Gender expression"

refers to the wide array of ways people display their gender through clothing, hair styles, mannerisms, or social roles. Exploring different ways of expressing gender is common for children and may challenge social expectations. The way others interpret this expression is referred to as "gender perception" (Table 1).^{5,6}

These labels may or may not be congruent. The term "cisgender" is used if someone identifies and expresses a gender that is consistent with the culturally defined norms of the sex that was assigned at birth. "Gender diverse" is an umbrella term to describe an ever-evolving array of labels that people may apply when their gender identity, expression, or even perception does not conform

to the norms and stereotypes others expect of their assigned sex. “Transgender” is usually reserved for a subset of such youth whose gender identity does not match their assigned sex and generally remains persistent, consistent, and insistent over time. These terms are not diagnoses; rather, they are personal and often dynamic ways of describing one’s own gender experience.

Gender identity is not synonymous with “sexual orientation,” which refers to a person’s identity in relation to the gender(s) to which they are sexually and romantically attracted. Gender identity and sexual orientation are distinct but interrelated constructs.⁸ Therefore, being transgender does not imply a sexual orientation, and people who identify as transgender still identify as straight, gay, bisexual, etc, on the basis of their attractions. (For more information, *The Gender Book*, found at www.thegenderbook.com, is a resource with illustrations that are used to highlight these core terms and concepts.)

EPIDEMIOLOGY

In population-based surveys, questions related to gender identity are rarely asked, which makes it difficult to assess the size and characteristics of the population that is TGD. In the 2014 Behavioral Risk Factor Surveillance System of the Centers for Disease Control and Prevention, only 19 states elected to include optional questions on gender identity. Extrapolation from these data suggests that the US prevalence of adults who identify as transgender or “gender nonconforming” is 0.6% (1.4 million), ranging from 0.3% in North Dakota to 0.8% in Hawaii.⁹ On the basis of these data, it has been estimated that 0.7% of youth ages 13 to 17 years (~150 000) identify as transgender.¹⁰ This number is much higher than previous estimates, which were

extrapolated from individual states or specialty clinics, and is likely an underestimate given the stigma regarding those who openly identify as transgender and the difficulty in defining “transgender” in a way that is inclusive of all gender-diverse identities.¹¹

There have been no large-scale prevalence studies among children and adolescents, and there is no evidence that adult statistics reflect young children or adolescents. In the 2014 Behavioral Risk Factor Surveillance System, those 18 to 24 years of age were more likely than older age groups to identify as transgender (0.7%).⁹ Children report being aware of gender incongruence at young ages. Children who later identify as TGD report first having recognized their gender as “different” at an average age of 8.5 years; however, they did not disclose such feelings until an average of 10 years later.¹²

MENTAL HEALTH IMPLICATIONS

Adolescents and adults who identify as transgender have high rates of depression, anxiety, eating disorders, self-harm, and suicide.^{13–20} Evidence suggests that an identity of TGD has an increased prevalence among individuals with autism spectrum disorder, but this association is not yet well understood.^{21,22} In 1 retrospective cohort study, 56% of youth who identified as transgender reported previous suicidal ideation, and 31% reported a previous suicide attempt, compared with 20% and 11% among matched youth who identified as cisgender, respectively.¹³ Some youth who identify as TGD also experience gender dysphoria, which is a specific diagnosis given to those who experience impairment in peer and/or family relationships, school performance, or other aspects of their life as a consequence of the

incongruence between their assigned sex and their gender identity.²³

There is no evidence that risk for mental illness is inherently attributable to one’s identity of TGD. Rather, it is believed to be multifactorial, stemming from an internal conflict between one’s appearance and identity, limited availability of mental health services, low access to health care providers with expertise in caring for youth who identify as TGD, discrimination, stigma, and social rejection.²⁴ This was affirmed by the American Psychological Association in 2008²⁵ (with practice guidelines released in 2015⁸) and the American Psychiatric Association, which made the following statement in 2012:

Being transgender or gender variant implies no impairment in judgment, stability, reliability, or general social or vocational capabilities; however, these individuals often experience discrimination due to a lack of civil rights protections for their gender identity or expression.... [Such] discrimination and lack of equal civil rights is damaging to the mental health of transgender and gender variant individuals.²⁶

Youth who identify as TGD often confront stigma and discrimination, which contribute to feelings of rejection and isolation that can adversely affect physical and emotional well-being. For example, many youth believe that they must hide their gender identity and expression to avoid bullying, harassment, or victimization. Youth who identify as TGD experience disproportionately high rates of homelessness, physical violence (at home and in the community), substance abuse, and high-risk sexual behaviors.^{5,6,12,27–31} Among the 3 million HIV testing events that were reported in 2015, the highest percentages of new infections were among women who identified as transgender³² and were also at particular risk for not knowing their HIV status.³⁰

GENDER-AFFIRMATIVE CARE

In a gender-affirmative care model (GACM), pediatric providers offer developmentally appropriate care that is oriented toward understanding and appreciating the youth's gender experience. A strong, nonjudgmental partnership with youth and their families can facilitate exploration of complicated emotions and gender-diverse expressions while allowing questions and concerns to be raised in a supportive environment.⁵ In a GACM, the following messages are conveyed:

- transgender identities and diverse gender expressions do not constitute a mental disorder;
- variations in gender identity and expression are normal aspects of human diversity, and binary definitions of gender do not always reflect emerging gender identities;
- gender identity evolves as an interplay of biology, development, socialization, and culture; and
- if a mental health issue exists, it most often stems from stigma and negative experiences rather than being intrinsic to the child.^{27,33}

The GACM is best facilitated through the integration of medical, mental health, and social services, including specific resources and supports for parents and families.²⁴ Providers work together to destigmatize gender variance, promote the child's self-worth, facilitate access to care, educate families, and advocate for safer community spaces where children are free to develop and explore their gender.⁵ A specialized gender-affirmative therapist, when available, may be an asset in helping children and their families build skills for dealing with gender-based stigma, address symptoms of anxiety or depression, and reinforce the child's overall resiliency.^{34,35} There is a limited but growing body

of evidence that suggests that using an integrated affirmative model results in young people having fewer mental health concerns whether they ultimately identify as transgender.^{24,36,37}

In contrast, "conversion" or "reparative" treatment models are used to prevent children and adolescents from identifying as transgender or to dissuade them from exhibiting gender-diverse expressions. The Substance Abuse and Mental Health Services Administration has concluded that any therapeutic intervention with the goal of changing a youth's gender expression or identity is inappropriate.³³ Reparative approaches have been proven to be not only unsuccessful³⁸ but also deleterious and are considered outside the mainstream of traditional medical practice.^{29,39–42} The AAP described reparative approaches as "unfair and deceptive."⁴³ At the time of this writing,^{*} conversion therapy was banned by executive regulation in New York and by legislative statutes in 9 other states as well as the District of Columbia.⁴⁴

Pediatric providers have an essential role in assessing gender concerns and providing evidence-based information to assist youth and families in medical decision-making. Not doing so can prolong or exacerbate gender dysphoria and contribute to abuse and stigmatization.³⁵ If a pediatric provider does not feel prepared to address gender concerns when they occur, then referral to a pediatric or mental health provider with more expertise is appropriate. There is little research on communication and efficacy with transfers in care for youth who identify as TGD,

particularly from pediatric to adult providers.

DEVELOPMENTAL CONSIDERATIONS

Acknowledging that the capacity for emerging abstract thinking in childhood is important to conceptualize and reflect on identity, gender-affirmation guidelines are being focused on individually tailored interventions on the basis of the physical and cognitive development of youth who identify as TGD.⁴⁵ Accordingly, research substantiates that children who are prepubertal and assert an identity of TGD know their gender as clearly and as consistently as their developmentally equivalent peers who identify as cisgender and benefit from the same level of social acceptance.⁴⁶ This developmental approach to gender affirmation is in contrast to the outdated approach in which a child's gender-diverse assertions are held as "possibly true" until an arbitrary age (often after pubertal onset) when they can be considered valid, an approach that authors of the literature have termed "watchful waiting." This outdated approach does not serve the child because critical support is withheld. Watchful waiting is based on binary notions of gender in which gender diversity and fluidity is pathologized; in watchful waiting, it is also assumed that notions of gender identity become fixed at a certain age. The approach is also influenced by a group of early studies with validity concerns, methodologic flaws, and limited follow-up on children who identified as TGD and, by adolescence, did not seek further treatment ("desisters").^{45,47} More robust and current research suggests that, rather than focusing on who a child will become, valuing them for who they are, even at a young age, fosters secure attachment and resilience, not only for the child but also for the whole family.^{5,45,48,49}

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@aap.org.

MEDICAL MANAGEMENT

Pediatric primary care providers are in a unique position to routinely inquire about gender development in children and adolescents as part of recommended well-child visits⁵⁰ and to be a reliable source of validation, support, and reassurance. They are often the first provider to be aware that a child may not identify as cisgender or that there may be distress related to a gender-diverse identity. The best way to approach gender with patients is to inquire directly and nonjudgmentally about their experience and feelings before applying any labels.^{27,51}

Many medical interventions can be offered to youth who identify as TGD and their families. The decision of whether and when to initiate gender-affirmative treatment is personal and involves careful consideration of risks, benefits, and other factors unique to each patient and family. Many protocols suggest that clinical assessment of youth who identify as TGD is ideally conducted on an ongoing basis in the setting of a collaborative, multidisciplinary approach, which, in addition to the patient and family, may include the pediatric provider, a mental health provider (preferably with expertise in caring for youth who identify as TGD), social and legal supports, and a pediatric endocrinologist or adolescent-medicine gender specialist, if available.^{6,28} There is no prescribed path, sequence, or end point. Providers can make every effort to be aware of the influence of their own biases. The medical options also vary depending on pubertal and developmental progression.

Clinical Setting

In the past year, 1 in 4 adults who identified as transgender avoided a necessary doctor's visit because of fear of being mistreated.³¹ All clinical office staff have a role in affirming a patient's gender identity. Making flyers available or displaying posters

related to LGBTQ health issues, including information for children who identify as TGD and families, reveals inclusivity and awareness. Generally, patients who identify as TGD feel most comfortable when they have access to a gender-neutral restroom. Diversity training that encompasses sensitivity when caring for youth who identify as TGD and their families can be helpful in educating clinical and administrative staff. A patient-asserted name and pronouns are used by staff and are ideally reflected in the electronic medical record without creating duplicate charts.^{52,53} The US Centers for Medicare and Medicaid Services and the National Coordinator for Health Information Technology require all electronic health record systems certified under the Meaningful Use incentive program to have the capacity to confidentially collect information on gender identity.^{54,55} Explaining and maintaining confidentiality procedures promotes openness and trust, particularly with youth who identify as LGBTQ.¹ Maintaining a safe clinical space can provide at least 1 consistent, protective refuge for patients and families, allowing authentic gender expression and exploration that builds resiliency.

Pubertal Suppression

Gonadotrophin-releasing hormones have been used to delay puberty since the 1980s for central precocious puberty.⁵⁶ These reversible treatments can also be used in adolescents who experience gender dysphoria to prevent development of secondary sex characteristics and provide time up until 16 years of age for the individual and the family to explore gender identity, access psychosocial supports, develop coping skills, and further define appropriate treatment goals. If pubertal suppression treatment is

suspended, then endogenous puberty will resume.^{20,57,58}

Often, pubertal suppression creates an opportunity to reduce distress that may occur with the development of secondary sexual characteristics and allow for gender-affirming care, including mental health support for the adolescent and the family. It reduces the need for later surgery because physical changes that are otherwise irreversible (protrusion of the Adam's apple, male pattern baldness, voice change, breast growth, etc) are prevented. The available data reveal that pubertal suppression in children who identify as TGD generally leads to improved psychological functioning in adolescence and young adulthood.^{20,57–59}

Pubertal suppression is not without risks. Delaying puberty beyond one's peers can also be stressful and can lead to lower self-esteem and increased risk taking.⁶⁰ Some experts believe that genital underdevelopment may limit some potential reconstructive options.⁶¹ Research on long-term risks, particularly in terms of bone metabolism⁶² and fertility,⁶³ is currently limited and provides varied results.^{57,64,65} Families often look to pediatric providers for help in considering whether pubertal suppression is indicated in the context of their child's overall well-being as gender diverse.

Gender Affirmation

As youth who identify as TGD reflect on and evaluate their gender identity, various interventions may be considered to better align their gender expression with their underlying identity. This process of reflection, acceptance, and, for some, intervention is known as "gender affirmation." It was formerly referred to as "transitioning," but many view the process as an affirmation and acceptance of who they have always been rather than a transition

TABLE 2 The Process of Gender Affirmation May Include ≥ 1 of the Following Components

Component	Definition	General Age Range ^a	Reversibility ^a
Social affirmation	Adopting gender-affirming hairstyles, clothing, name, gender pronouns, and restrooms and other facilities	Any	Reversible
Puberty blockers	Gonadotropin-releasing hormone analogues, such as leuprolide and histrelin	During puberty (Tanner stage 2–5) ^b	Reversible ^c
Cross-sex hormone therapy	Testosterone (for those who were assigned female at birth and are masculinizing); estrogen plus androgen inhibitor (for those who were assigned male at birth and are feminizing)	Early adolescence onward	Partially reversible (skin texture, muscle mass, and fat deposition); irreversible once developed (testosterone: Adam’s apple protrusion, voice changes, and male pattern baldness; estrogen: breast development); unknown reversibility (effect on fertility)
Gender-affirming surgeries	“Top” surgery (to create a male-typical chest shape or enhance breasts); “bottom” surgery (surgery on genitals or reproductive organs); facial feminization and other procedures	Typically adults (adolescents on case-by-case basis ^d)	Not reversible
Legal affirmation	Changing gender and name recorded on birth certificate, school records, and other documents	Any	Reversible

^a Note that the provided age range and reversibility is based on the little data that are currently available.

^b There is limited benefit to starting gonadotropin-releasing hormone after Tanner stage 5 for pubertal suppression. However, when cross-sex hormones are initiated with a gradually increasing schedule, the initial levels are often not high enough to suppress endogenous sex hormone secretion. Therefore, gonadotropin-releasing hormone may be continued in accordance with the Endocrine Society Guidelines.⁶⁸

^c The effect of sustained puberty suppression on fertility is unknown. Pubertal suppression can be, and often is indicated to be, followed by cross-sex hormone treatment. However, when cross-sex hormones are initiated without endogenous hormones, then fertility may be decreased.⁶⁸

^d Eligibility criteria for gender-affirmative surgical interventions among adolescents are not clearly defined between established protocols and practice. When applicable, eligibility is usually determined on a case-by-case basis with the adolescent and the family along with input from medical, mental health, and surgical providers.^{68–71}

from 1 gender identity to another. Accordingly, some people who have gone through the process prefer to call themselves “affirmed females, males, etc” (or just “females, males, etc”), rather than using the prefix “trans-.” Gender affirmation is also used to acknowledge that some individuals who identify as TGD may feel affirmed in their gender without pursuing medical or surgical interventions.^{7,66}

Supportive involvement of parents and family is associated with better mental and physical health outcomes.⁶⁷ Gender affirmation among adolescents with gender dysphoria often reduces the emphasis on gender in their lives, allowing them to attend to other developmental tasks, such as academic success, relationship building, and future-oriented planning.⁶⁴ Most protocols for gender-affirming interventions incorporate World Professional Association of Transgender

Health³⁵ and Endocrine Society⁶⁸ recommendations and include ≥ 1 of the following elements (Table 2):

1. Social Affirmation: This is a reversible intervention in which children and adolescents express partially or completely in their asserted gender identity by adapting hairstyle, clothing, pronouns, name, etc. Children who identify as transgender and socially affirm and are supported in their asserted gender show no increase in depression and only minimal (clinically insignificant) increases in anxiety compared with age-matched averages.⁴⁸ Social affirmation can be complicated given the wide range of social interactions children have (eg, extended families, peers, school, community, etc). There is little guidance on the best approach (eg, all at once, gradual, creating new social networks, or affirming within existing networks, etc). Pediatric providers

can best support families by anticipating and discussing such complexity proactively, either in their own practice or through enlisting a qualified mental health provider.

2. Legal Affirmation: Elements of a social affirmation, such as a name and gender marker, become official on legal documents, such as birth certificates, passports, identification cards, school documents, etc. The processes for making these changes depend on state laws and may require specific documentation from pediatric providers.
3. Medical Affirmation: This is the process of using cross-sex hormones to allow adolescents who have initiated puberty to develop secondary sex characteristics of the opposite biological sex. Some changes are partially reversible if hormones are stopped, but others become

irreversible once they are fully developed (Table 2).

4. **Surgical Affirmation:** Surgical approaches may be used to feminize or masculinize features, such as hair distribution, chest, or genitalia, and may include removal of internal organs, such as ovaries or the uterus (affecting fertility). These changes are irreversible. Although current protocols typically reserve surgical interventions for adults,^{35,68} they are occasionally pursued during adolescence on a case-by-case basis, considering the necessity and benefit to the adolescent's overall health and often including multidisciplinary input from medical, mental health, and surgical providers as well as from the adolescent and family.^{69–71}

For some youth who identify as TGD whose natal gender is female, menstruation, breakthrough bleeding, and dysmenorrhea can lead to significant distress before or during gender affirmation. The American College of Obstetrics and Gynecology suggests that, although limited data are available to outline management, menstruation can be managed without exogenous estrogens by using a progesterone-only pill, a medroxyprogesterone acetate shot, or a progesterone-containing intrauterine or implantable device.⁷² If estrogen can be tolerated, oral contraceptives that contain both progesterone and estrogen are more effective at suppressing menses.⁷³ The Endocrine Society guidelines also suggest that gonadotrophin-releasing hormones can be used for menstrual suppression before the anticipated initiation of testosterone or in combination with testosterone for breakthrough bleeding (enables phenotypic masculinization at a lower dose than if testosterone is used alone).⁶⁸ Masculinizing hormones in natal female patients may lead to a cessation of menses,

but unplanned pregnancies have been reported, which emphasizes the need for ongoing contraceptive counseling with youth who identify as TGD.⁷²

HEALTH DISPARITIES

In addition to societal challenges, youth who identify as TGD face several barriers within the health care system, especially regarding access to care. In 2015, a focus group of youth who identified as transgender in Seattle, Washington, revealed 4 problematic areas related to health care:

1. safety issues, including the lack of safe clinical environments and fear of discrimination by providers;
2. poor access to physical health services, including testing for sexually transmitted infections;
3. inadequate resources to address mental health concerns; and
4. lack of continuity with providers.⁷⁴

This study reveals the obstacles many youth who identify as TGD face in accessing essential services, including the limited supply of appropriately trained medical and psychological providers, fertility options, and insurance coverage denials for gender-related treatments.⁷⁴

Insurance denials for services related to the care of patients who identify as TGD are a significant barrier. Although the Office for Civil Rights of the US Department of Health and Human Services explicitly stated in 2012 that the nondiscrimination provision in the Patient Protection and Affordable Care Act includes people who identify as gender diverse,^{75,76} insurance claims for gender affirmation, particularly among youth who identify as TGD, are frequently denied.^{54,77} In 1 study, it was found that approximately 25% of individuals

who identified as transgender were denied insurance coverage because of being transgender.³¹ The burden of covering medical expenses that are not covered by insurance can be financially devastating, and even when expenses are covered, families describe high levels of stress in navigating and submitting claims appropriately.⁷⁸ In 2012, a large gender center in Boston, Massachusetts, reported that most young patients who identified as transgender and were deemed appropriate candidates for recommended gender care were unable to obtain it because of such denials, which were based on the premise that gender dysphoria was a mental disorder, not a physical one, and that treatment was not medically or surgically necessary.²⁴ This practice not only contributes to stigma, prolonged gender dysphoria, and poor mental health outcomes,⁷⁷ but it may also lead patients to seek nonmedically supervised treatments that are potentially dangerous.²⁴ Furthermore, insurance denials can reinforce a socioeconomic divide between those who can finance the high costs of uncovered care and those who cannot.^{24,77}

The transgender youth group in Seattle likely reflected the larger TGD population when they described how obstacles adversely affect self-esteem and contribute to the perception that they are undervalued by society and the health care system.^{74,77} Professional medical associations, including the AAP, are increasingly calling for equity in health care provisions regardless of gender identity or expression.^{1,8,23,72} There is a critical need for investments in research on the prevalence, disparities, biological underpinnings, and standards of care relating to gender-diverse populations. Pediatric providers who work with state government and insurance officials can play an essential role in advocating for

stronger nondiscrimination policies and improved coverage.

There is a lack of quality research on the experience of youth of color who identify as transgender. One theory suggests that the intersection of racism, transphobia, and sexism may result in the extreme marginalization that is experienced among many women of color who identify as transgender,⁷⁹ including rejection from their family and dropping out of school at younger ages (often in the setting of rigid religious beliefs regarding gender),⁸⁰ increased levels of violence and body objectification,⁸¹ 3 times the risk of poverty compared with the general population,³¹ and the highest prevalence of HIV compared with other risk groups (estimated as high as 56.3% in 1 meta-analysis).³⁰ One model suggests that pervasive stigma and oppression can be associated with psychological distress (anxiety, depression, and suicide) and adoption of risk behaviors by such youth to obtain a sense of validation toward their complex identities.⁷⁹

FAMILY ACCEPTANCE

Research increasingly suggests that familial acceptance or rejection ultimately has little influence on the gender identity of youth; however, it may profoundly affect young people's ability to openly discuss or disclose concerns about their identity. Suppressing such concerns can affect mental health.⁸² Families often find it hard to understand and accept their child's gender-diverse traits because of personal beliefs, social pressure, and stigma.^{49,83} Legitimate fears may exist for their child's welfare, safety, and acceptance that pediatric providers need to appreciate and address. Families can be encouraged to communicate their concerns and questions. Unacknowledged concerns can contribute to shame and hesitation in regard to offering support and understanding.⁸⁴

which is essential for the child's self-esteem, social involvement, and overall health as TGD.^{48,85–87} Some caution has been expressed that unquestioning acceptance per se may not best serve questioning youth or their families. Instead, psychological evidence suggests that the most benefit comes when family members and youth are supported and encouraged to engage in reflective perspective taking and validate their own and the other's thoughts and feelings despite divergent views.^{49,82}

In this regard, suicide attempt rates among 433 adolescents in Ontario who identified as “trans” were 4% among those with strongly supportive parents and as high as 60% among those whose parents were not supportive.⁸⁵ Adolescents who identify as transgender and endorse at least 1 supportive person in their life report significantly less distress than those who only experience rejection. In communities with high levels of support, it was found that nonsupportive families tended to increase their support over time, leading to dramatic improvement in mental health outcomes among their children who identified as transgender.⁸⁸

Pediatric providers can create a safe environment for parents and families to better understand and listen to the needs of their children while receiving reassurance and education.⁸³ It is often appropriate to assist the child in understanding the parents' concerns as well. Despite expectations by some youth with transgender identity for immediate acceptance after “coming out,” family members often proceed through a process of becoming more comfortable and understanding of the youth's gender identity, thoughts, and feelings. One model suggests that the process resembles grieving, wherein the family separates from their expectations for their child to embrace a new reality. This process may proceed through stages of shock,

denial, anger, feelings of betrayal, fear, self-discovery, and pride.⁸⁹ The amount of time spent in any of these stages and the overall pace varies widely. Many family members also struggle as they are pushed to reflect on their own gender experience and assumptions throughout this process. In some situations, youth who identify as TGD may be at risk for internalizing the difficult emotions that family members may be experiencing. In these cases, individual and group therapy for the family members may be helpful.^{49,78}

Family dynamics can be complex, involving disagreement among legal guardians or between guardians and their children, which may affect the ability to obtain consent for any medical management or interventions. Even in states where minors may access care without parental consent for mental health services, contraception, and sexually transmitted infections, parental or guardian consent is required for hormonal and surgical care of patients who identify as TGD.^{72,90} Some families may take issue with providers who address gender concerns or offer gender-affirming care. In rare cases, a family may deny access to care that raises concerns about the youth's welfare and safety; in those cases, additional legal or ethical support may be useful to consider. In such rare situations, pediatric providers may want to familiarize themselves with relevant local consent laws and maintain their primary responsibility for the welfare of the child.

SAFE SCHOOLS AND COMMUNITIES

Youth who identify as TGD are becoming more visible because gender-diverse expression is increasingly admissible in the media, on social media, and in schools and communities. Regardless of whether a youth with a gender-diverse

identity ultimately identifies as transgender, challenges exist in nearly every social context, from lack of understanding to outright rejection, isolation, discrimination, and victimization. In the US Transgender Survey of nearly 28 000 respondents, it was found that among those who were out as or perceived to be TGD between kindergarten and eighth grade, 54% were verbally harassed, 24% were physically assaulted, and 13% were sexually assaulted; 17% left school because of maltreatment.³¹ Education and advocacy from the medical community on the importance of safe schools for youth who identify as TGD can have a significant effect.

At the time of this writing,* only 18 states and the District of Columbia had laws that prohibited discrimination based on gender expression when it comes to employment, housing, public accommodations, and insurance benefits. Over 200 US cities have such legislation. In addition to basic protections, many youth who identify as TGD also have to navigate legal obstacles when it comes to legally changing their name and/or gender marker.⁵⁴ In addition to advocating and working with policy makers to promote equal protections for youth who identify as TGD, pediatric providers can play an important role by developing a familiarity with local laws and organizations that provide social work and legal assistance to youth who identify as TGD and their families.

School environments play a significant role in the social and emotional development of children. Every child has a right to feel safe

and respected at school, but for youth who identify as TGD, this can be challenging. Nearly every aspect of school life may present safety concerns and require negotiations regarding their gender expression, including name/pronoun use, use of bathrooms and locker rooms, sports teams, dances and activities, overnight activities, and even peer groups. Conflicts in any of these areas can quickly escalate beyond the school's control to larger debates among the community and even on a national stage.

The formerly known Gay, Lesbian, and Straight Education Network (GLSEN), an advocacy organization for youth who identify as LGBTQ, conducts an annual national survey to measure LGBTQ well-being in US schools. In 2015, students who identified as LGBTQ reported high rates of being discouraged from participation in extracurricular activities. One in 5 students who identified as LGBTQ reported being hindered from forming or participating in a club to support lesbian, gay, bisexual, or transgender students (eg, a gay straight alliance, now often referred to as a genders and sexualities alliance) despite such clubs at schools being associated with decreased reports of negative remarks about sexual orientation or gender expression, increased feelings of safety and connectedness at school, and lower levels of victimization. In addition, >20% of students who identified as LGBTQ reported being blocked from writing about LGBTQ issues in school yearbooks or school newspapers or being prevented or discouraged by coaches and school staff from participating in sports because of their sexual orientation or gender expression.⁹¹

One strategy to prevent conflict is to proactively support policies and protections that promote inclusion and safety of all students. However, such policies are far from

consistent across districts. In 2015, GLSEN found that 43% of children who identified as LGBTQ reported feeling unsafe at school because of their gender expression, but only 6% reported that their school had official policies to support youth who identified as TGD, and only 11% reported that their school's antibullying policies had specific protections for gender expression.⁹¹ Consequently, more than half of the students who identified as transgender in the study were prevented from using the bathroom, names, or pronouns that aligned with their asserted gender at school. A lack of explicit policies that protected youth who identified as TGD was associated with increased reported victimization, with more than half of students who identified as LGBTQ reporting verbal harassment because of their gender expression. Educators and school administrators play an essential role in advocating for and enforcing such policies. GLSEN found that when students recognized actions to reduce gender-based harassment, both students who identified as transgender and cisgender reported a greater connection to staff and feelings of safety.⁹¹ In another study, schools were open to education regarding gender diversity and were willing to implement policies when they were supported by external agencies, such as medical professionals.⁹²

Academic content plays an important role in building a safe school environment as well. The 2015 GLSEN survey revealed that when positive representations of people who identified as LGBTQ were included in the curriculum, students who identified as LGBTQ reported less hostile school environments, less victimization and greater feelings of safety, fewer school absences because of feeling unsafe, greater feelings of connectedness to their school

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@aap.org.

community, and an increased interest in high school graduation and postsecondary education.⁹¹ At the time of this writing,* 8 states had laws that explicitly forbade teachers from even discussing LGBTQ issues.⁵⁴

MEDICAL EDUCATION

One of the most important ways to promote high-quality health care for youth who identify as TGD and their families is increasing the knowledge base and clinical experience of pediatric providers in providing culturally competent care to such populations, as recommended by the recently released guidelines by the Association of American Medical Colleges.⁹³ This begins with the medical school curriculum in areas such as human development, sexual health, endocrinology, pediatrics, and psychiatry. In a 2009–2010 survey of US medical schools, it was found that the median number of hours dedicated to LGBTQ health was 5, with one-third of US medical schools reporting no LGBTQ curriculum during the clinical years.⁹⁴

During residency training, there is potential for gender diversity to be emphasized in core rotations, especially in pediatrics, psychiatry, family medicine, and obstetrics and gynecology. Awareness could be promoted through the inclusion of topics relevant to caring for children who identify as TGD in the list of core competencies published by the American Board of Pediatrics, certifying examinations, and relevant study materials. Continuing education and maintenance of certification activities can include topics relevant to TGD populations as well.

* For more information regarding state-specific laws, please contact the AAP Division of State Government Affairs at stgov@aap.org.

RECOMMENDATIONS

The AAP works toward all children and adolescents, regardless of gender identity or expression, receiving care to promote optimal physical, mental, and social well-being. Any discrimination based on gender identity or expression, real or perceived, is damaging to the socioemotional health of children, families, and society. In particular, the AAP recommends the following:

1. that youth who identify as TGD have access to comprehensive, gender-affirming, and developmentally appropriate health care that is provided in a safe and inclusive clinical space;
2. that family-based therapy and support be available to recognize and respond to the emotional and mental health needs of parents, caregivers, and siblings of youth who identify as TGD;
3. that electronic health records, billing systems, patient-centered notification systems, and clinical research be designed to respect the asserted gender identity of each patient while maintaining confidentiality and avoiding duplicate charts;
4. that insurance plans offer coverage for health care that is specific to the needs of youth who identify as TGD, including coverage for medical, psychological, and, when indicated, surgical gender-affirming interventions;
5. that provider education, including medical school, residency, and continuing education, integrate core competencies on the emotional and physical health needs and best practices for the care of youth who identify as TGD and their families;
6. that pediatricians have a role in advocating for, educating, and developing liaison relationships

with school districts and other community organizations to promote acceptance and inclusion of all children without fear of harassment, exclusion, or bullying because of gender expression;

7. that pediatricians have a role in advocating for policies and laws that protect youth who identify as TGD from discrimination and violence;
8. that the health care workforce protects diversity by offering equal employment opportunities and workplace protections, regardless of gender identity or expression; and
9. that the medical field and federal government prioritize research that is dedicated to improving the quality of evidence-based care for youth who identify as TGD.

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ABBREVIATIONS

AAP: American Academy of Pediatrics
GACM: gender-affirmative care model
GLSEN: Gay, Lesbian, and Straight Education Network
LGBTQ: lesbian, gay, bisexual, transgender, or questioning
TGD: transgender and gender diverse

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DOC. 69-25

Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

American Psychological Association

Transgender and gender nonconforming¹ (TGNC) people are those who have a gender identity that is not fully aligned with their sex assigned at birth. The existence of TGNC people has been documented in a range of historical cultures (Coleman, Colgan, & Gooren, 1992; Feinberg, 1996; Miller & Nichols, 2012; Schmidt, 2003). Current population estimates of TGNC people have ranged from 0.17 to 1,333 per 100,000 (Meier & Labuski, 2013). The Massachusetts Behavioral Risk Factor Surveillance Survey found 0.5% of the adult population aged 18 to 64 years identified as TGNC between 2009 and 2011 (Conron, Scott, Stowell, & Landers, 2012). However, population estimates likely underreport the true number of TGNC people, given difficulties in collecting comprehensive demographic information about this group (Meier & Labuski, 2013). Within the last two decades, there has been a significant increase in research about TGNC people. This increase in knowledge, informed by the TGNC community, has resulted in the development of progressively more trans-affirmative practice across the multiple health disciplines involved in the care of TGNC people (Bockting, Knudson, & Goldberg, 2006; Coleman et al., 2012). Research has documented the extensive experiences of stigma and discrimination reported by TGNC people (Grant et al., 2011) and the mental health consequences of these experiences across the life span (Bockting, Miner, Swinburne Romine, Hamilton, & Coleman, 2013), including increased rates of depression (Fredriksen-Goldsen et al., 2014) and suicidality (Clements-Nolle, Marx, & Katz, 2006). TGNC people's lack of access to trans-affirmative mental and physical health care is a common barrier (Fredriksen-Goldsen et al., 2014; Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Grossman & D'Augelli, 2006), with TGNC people sometimes being denied care because of their gender identity (Xavier et al., 2012).

In 2009, the American Psychological Association (APA) Task Force on Gender Identity and Gender Variance (TFGIGV) survey found that less than 30% of psychologist and graduate student participants reported familiarity with issues that TGNC people experience (APA TFGIGV, 2009). Psychologists and other mental health professionals who have limited training and experience in TGNC-affirmative care may cause harm to TGNC people (Mikalson, Pardo, & Green, 2012; Xavier et al., 2012). The significant level of societal stigma and discrimination that TGNC people face, the associated mental health consequences, and psychologists' lack of familiarity with trans-affirmative care led the APA Task Force to recommend that psycho-

logical practice guidelines be developed to help psychologists maximize the effectiveness of services offered and avoid harm when working with TGNC people and their families.

Purpose

The purpose of the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (hereafter *Guidelines*) is to assist psychologists in the provision of culturally competent, developmentally appropriate, and trans-affirmative psychological practice with TGNC people. Trans-affirmative practice is the provision

The American Psychological Association's (APA's) Task Force on Guidelines for Psychological Practice with Transgender and Gender Nonconforming People developed these guidelines. Lore M. Dickey, Louisiana Tech University, and Anneliese A. Singh, The University of Georgia, served as chairs of the Task Force. The members of the Task Force included Walter O. Bockting, Columbia University; Sand Chang, Independent Practice; Kelly Ducheny, Howard Brown Health Center; Laura Edwards-Leeper, Pacific University; Randall D. Ehrbar, Whitman Walker Health Center; Max Fuentes Fuhrmann, Independent Practice; Michael L. Hendricks, Washington Psychological Center, P.C.; and Ellen Magalhaes, Center for Psychological Studies at Nova Southeastern University and California School of Professional Psychology at Alliant International University.

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This document will expire as APA policy in 2022. After this date, users should contact the APA Public Interest Directorate to determine whether the guidelines in this document remain in effect as APA policy.

Correspondence concerning this article should be addressed to the Public Interest Directorate, American Psychological Association, 750 First Street, NE, Washington, DC 20002.

¹ For the purposes of these guidelines, we use the term *transgender and gender nonconforming* (TGNC). We intend for the term to be as broadly inclusive as possible, and recognize that some TGNC people do not ascribe to these terms. Readers are referred to [Appendix A](#) for a listing of terms that include various TGNC identity labels.

of care that is respectful, aware, and supportive of the identities and life experiences of TGNC people (Korell & Lorah, 2007). The *Guidelines* are an introductory resource for psychologists who will encounter TGNC people in their practice, but can also be useful for psychologists with expertise in this area of practice to improve the care already offered to TGNC people. The *Guidelines* include a set of definitions for readers who may be less familiar with language used when discussing gender identity and TGNC populations (see Appendix A). Distinct from TGNC, the term “cisgender” is used to refer to people whose sex assigned at birth is aligned with their gender identity (E. R. Green, 2006; Serano, 2006).

Given the added complexity of working with TGNC and gender-questioning youth² and the limitations of the available research, the *Guidelines* focus primarily, though not exclusively, on TGNC adults. Future revisions of the *Guidelines* will deepen a focus on TGNC and gender-questioning children and adolescents. The *Guidelines* address the strengths of TGNC people, the challenges they face, ethical and legal issues, life span considerations, research, education, training, and health care. Because issues of gender identity are often conflated with issues of gender expression or sexual orientation, psychological practice with the TGNC population warrants the acquisition of specific knowledge about concerns unique to TGNC people that are not addressed by other practice guidelines (APA, 2012). It is important to note that these *Guidelines* are not intended to address some of the conflicts that cisgender people may experience due to societal expectations regarding gender roles (Butler, 1990), nor are they intended to address intersex people (Dreger, 1999; Preves, 2003).

Documentation of Need

In 2005, the APA Council of Representatives authorized the creation of the Task Force on Gender Identity and Gender Variance (TFGIGV), charging the Task Force to review APA policies related to TGNC people and to offer recommendations for APA to best meet the needs of TGNC people (APA TFGIGV, 2009). In 2009, the APA Council of Representatives adopted the Resolution on Transgender, Gender Identity, & Gender Expression Non-Discrimination, which calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment; encourages psychologists to take a leadership role in working against discrimination; supports the provision of adequate and necessary mental and medical health care; recognizes the efficacy, benefit, and medical necessity of gender transition; supports access to appropriate treatment in institutional settings; and supports the creation of educational resources for all psychologists (Anton, 2009). In 2009, in an extensive report on the current state of psychological practice with TGNC people, the TFGIGV determined that there was sufficient knowledge and expertise in the field to warrant the development of practice guidelines for TGNC populations (APA TFGIGV, 2009). The report identified that TGNC people constituted a population with

unique needs and that the creation of practice guidelines would be a valuable resource for the field (APA TFGIGV, 2009). Psychologists’ relative lack of knowledge about TGNC people and trans-affirmative care, the level of societal stigma and discrimination that TGNC people face, and the significant mental health consequences that TGNC people experience as a result offer a compelling need for psychological practice guidelines for this population.

Users

The intended audience for these *Guidelines* includes psychologists who provide clinical care, conduct research, or provide education or training. Given that gender identity issues can arise at any stage in a TGNC person’s life (Lev, 2004), clinicians can encounter a TGNC person in practice or have a client’s presenting problem evolve into an issue related to gender identity and gender expression. Researchers, educators, and trainers will benefit from use of these *Guidelines* to inform their work, even when not specifically focused on TGNC populations. Psychologists who focus on TGNC populations in their clinical practice, research, or educational and training activities will also benefit from the use of these *Guidelines*.

Distinction Between Standards and Guidelines

When using these *Guidelines*, psychologists should be aware that APA has made an important distinction between *standards* and *guidelines* (Reed, McLaughlin, & Newman, 2002). Standards are mandates to which all psychologists must adhere (e.g., the *Ethical Principles of Psychologists and Code of Conduct*; APA, 2010), whereas guidelines are aspirational. Psychologists are encouraged to use these *Guidelines* in tandem with the *Ethical Principles of Psychologists and Code of Conduct*, and should be aware that state and federal laws may override these *Guidelines* (APA, 2010).

In addition, these *Guidelines* refer to psychological practice (e.g., clinical work, consultation, education, research, and training) rather than treatment. Practice guidelines are practitioner-focused and provide guidance for professionals regarding “conduct and the issues to be considered in particular areas of clinical practice” (Reed et al., 2002, p. 1044). Treatment guidelines are client-focused and address intervention-specific recommendations for a clinical population or condition (Reed et al., 2002). The current *Guidelines* are intended to complement treatment guidelines for TGNC people seeking mental health services, such as those set forth by the World Professional Association for Transgender Health Standards of Care (Coleman et al., 2012) and the Endocrine Society (Hembree et al., 2009).

² For the purposes of these guidelines, “youth” refers to both children and adolescents under the age of 18.

Compatibility

These *Guidelines* are consistent with the APA *Ethical Principles of Psychologists and Code of Conduct* (APA, 2010), the *Standards of Accreditation for Health Service Psychology* (APA, 2015), the APA TFGIGV (2009) report, and the APA Council of Representatives Resolution on Transgender, Gender Identity, & Gender Expression Non-Discrimination (Anton, 2009).

Practice Guidelines Development Process

To address one of the recommendations of the APA TFGIGV (2009), the APA Committee on Sexual Orientation and Gender Diversity (CSOGD; then the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns) and Division 44 (the Society for the Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues) initiated a joint Task Force on Psychological Practice Guidelines with Transgender and Gender Nonconforming People in 2011. Task Force members were selected through an application and review process conducted by the leadership of CSOGD and Division 44. The Task Force included 10 members who had substantial psychological practice expertise with TGNC people. Of the 10 task force members, five individuals identified as TGNC with a range of gender identities and five identified as cisgender. In terms of race/ethnicity, six of the task force members identified as White and four identified as people of color (one Indian American, one Chinese American, one Latina American, and one mixed race).

The Task Force conducted a comprehensive review of the extant scholarship, identified content most pertinent to the practice of psychology with TGNC people, and evaluated the level of evidence to support guidance within each guideline. To ensure the accuracy and comprehensiveness of these *Guidelines*, Task Force members met with TGNC community members and groups and consulted with subject matter experts within and outside of psychology. When the Task Force discovered a lack of professional consensus, every effort was made to include divergent opinions in the field relevant to that issue. When this occurred, the Task Force described the various approaches documented in the literature. Additionally, these *Guidelines* were informed by comments received at multiple presentations held at professional conferences and comments obtained through two cycles of open public comment on earlier *Guideline* drafts.

This document contains 16 guidelines for TGNC psychological practice. Each guideline includes a Rationale section, which reviews relevant scholarship supporting the need for the guideline, and an Application section, which describes how the particular guideline may be applied in psychological practice. The *Guidelines* are organized into five clusters: (a) foundational knowledge and awareness; (b) stigma, discrimination, and barriers to care; (c) life span development; (d) assessment, therapy, and intervention; and (e) research, education, and training.

Funding for this project was provided by Division 44 (Society for the Psychological Study of LGBT Issues); the

APA Office on Lesbian, Gay, Bisexual, and Transgender (LGBT) Concerns; a grant from the Committee on Division/APA Relations (CODAPAR); and donations from Randall Ehrbar and Pamela St. Amand. Some members of the Task Force have received compensation through presentations (e.g., honoraria) or royalties (e.g., book contracts) based in part on information contained in these *Guidelines*.

Selection of Evidence

Although the number of publications on the topic of TGNC-affirmative practice has been increasing, this is still an emerging area of scholarly literature and research. When possible, the Task Force relied on peer-reviewed publications, but books, chapters, and reports that do not typically receive a high level of peer review have also been cited when appropriate. These sources are from a diverse range of fields addressing mental health, including psychology, counseling, social work, and psychiatry. Some studies of TGNC people utilize small sample sizes, which limits the generalizability of results. Few studies of TGNC people utilize probability samples or randomized control groups (e.g., Conron et al., 2012; Dhejne et al., 2011). As a result, the Task Force relied primarily on studies using convenience samples, which limits the generalizability of results to the population as a whole, but can be adequate for describing issues and situations that arise within the population.

Foundational Knowledge and Awareness

Guideline 1. Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person's gender identity may not align with sex assigned at birth.

Rationale. Gender identity is defined as a person's deeply felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender (Bethea & McCollum, 2013; Institute of Medicine [IOM], 2011). In many cultures and religious traditions, gender has been perceived as a binary construct, with mutually exclusive categories of male or female, boy or girl, man or woman (Benjamin, 1966; Mollenkott, 2001; Tanis, 2003). These mutually exclusive categories include an assumption that gender identity is always in alignment with sex assigned at birth (Bethea & McCollum, 2013). For TGNC people, gender identity differs from sex assigned at birth to varying degrees, and may be experienced and expressed outside of the gender binary (Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012).

Gender as a nonbinary construct has been described and studied for decades (Benjamin, 1966; Herdt, 1994; Kulick, 1998). There is historical evidence of recognition, societal acceptance, and sometimes reverence of diversity in gender identity and gender expression in several different cultures (Coleman et al., 1992; Feinberg, 1996; Miller

& Nichols, 2012; Schmidt, 2003). Many cultures in which gender nonconforming persons and groups were visible were diminished by westernization, colonialism, and systemic inequity (Nanda, 1999). In the 20th century, TGNC expression became medicalized (Hirschfeld, 1910/1991), and medical interventions to treat discordance between a person's sex assigned at birth, secondary sex characteristics, and gender identity became available (Meyerowitz, 2002).

As early as the 1950s, research found variability in how an individual described their³ gender, with some participants reporting a gender identity different from the culturally defined, mutually exclusive categories of "man" or "woman" (Benjamin, 1966). In several recent large online studies of the TGNC population in the United States, 30% to 40% of participants identified their gender identity as other than man or woman (Harrison et al., 2012; Kuper et al., 2012). Although some studies have cultivated a broader understanding of gender (Conron, Scout, & Austin, 2008), the majority of research has required a forced choice between man and woman, thus failing to represent or depict those with different gender identities (IOM, 2011). Research over the last two decades has demonstrated the existence of a wide spectrum of gender identity and gender expression (Bockting, 2008; Harrison et al., 2012; Kuper et al., 2012), which includes people who identify as either man or woman, neither man nor woman, a blend of man and woman, or a unique gender identity. A person's identification as TGNC can be healthy and self-affirming, and is not inherently pathological (Coleman et al., 2012). However, people may experience distress associated with discordance between their gender identity and their body or sex assigned at birth, as well as societal stigma and discrimination (Coleman et al., 2012).

Between the late 1960s and the early 1990s, health care to alleviate gender dysphoria largely reinforced a binary conceptualization of gender (APA TFGIGV, 2009; Bolin, 1994; Hastings, 1974). At that time, it was considered an ideal outcome for TGNC people to conform to an identity that aligned with either sex assigned at birth or, if not possible, with the "opposite" sex, with a heavy emphasis on blending into the cisgender population or "passing" (APA TFGIGV, 2009; Bolin, 1994; Hastings, 1974). Variance from these options could raise concern for health care providers about a TGNC person's ability to transition successfully. These concerns could act as a barrier to accessing surgery or hormone therapy because medical and mental health care provider endorsement was required before surgery or hormones could be accessed (Berger et al., 1979). Largely because of self-advocacy of TGNC individuals and communities in the 1990s, combined with advances in research and models of trans-affirmative care, there is greater recognition and acknowledgment of a spectrum of gender diversity and corresponding individualized, TGNC-specific health care (Bockting et al., 2006; Coleman et al., 2012).

Application. A nonbinary understanding of gender is fundamental to the provision of affirmative care for TGNC people. Psychologists are encouraged to adapt or

modify their understanding of gender, broadening the range of variation viewed as healthy and normative. By understanding the spectrum of gender identities and gender expressions that exist, and that a person's gender identity may not be in full alignment with sex assigned at birth, psychologists can increase their capacity to assist TGNC people, their families, and their communities (Lev, 2004). Respecting and supporting TGNC people in authentically articulating their gender identity and gender expression, as well as their lived experience, can improve TGNC people's health, well-being, and quality of life (Witten, 2003).

Some TGNC people may have limited access to visible, positive TGNC role models. As a result, many TGNC people are isolated and must cope with the stigma of gender nonconformity without guidance or support, worsening the negative effect of stigma on mental health (Fredriksen-Goldsen et al., 2014; Singh, Hays, & Watson, 2011). Psychologists may assist TGNC people in challenging gender norms and stereotypes, and in exploring their unique gender identity and gender expression. TGNC people, partners, families, friends, and communities can benefit from education about the healthy variation of gender identity and gender expression, and the incorrect assumption that gender identity automatically aligns with sex assigned at birth.

Psychologists may model an acceptance of ambiguity as TGNC people develop and explore aspects of their gender, especially in childhood and adolescence. A non-judgmental stance toward gender nonconformity can help to counteract the pervasive stigma faced by many TGNC people and provide a safe environment to explore gender identity and make informed decisions about gender expression.

Guideline 2. Psychologists understand that gender identity and sexual orientation are distinct but interrelated constructs.

Rationale. The constructs of gender identity and sexual orientation are theoretically and clinically distinct, even though professionals and nonprofessionals frequently conflate them. Although some research suggests a potential link in the development of gender identity and sexual orientation, the mechanisms of such a relationship are unknown (Adelson & American Academy of Child and Adolescent Psychiatry [AACAP] Committee on Quality Issues [CQI], 2012; APA TFGIGV, 2009; A. H. Devor, 2004; Drescher & Byne, 2013). *Sexual orientation* is defined as a person's sexual and/or emotional attraction to another person (Shively & De Cecco, 1977), compared with *gender identity*, which is defined by a person's felt, inherent sense of gender. For most people, gender identity develops earlier than sexual orientation. Gender identity is often established in young toddlerhood (Adelson & AACAP CQI, 2012; Kohlberg, 1966), compared with aware-

³ The third person plural pronouns "they," "them," and "their" in some instances function in these guidelines as third-person singular pronouns to model a common technique used to avoid the use of gendered pronouns when speaking to or about TGNC people.

ness of same-sex attraction, which often emerges in early adolescence (Adelson & AACAP CQI, 2012; D'Augelli & Hershberger, 1993; Herdt & Boxer, 1993; Ryan, 2009; Savin-Williams & Diamond, 2000). Although gender identity is usually established in childhood, individuals may become aware that their gender identity is not in full alignment with sex assigned at birth in childhood, adolescence, or adulthood. The developmental pathway of gender identity typically includes a progression through multiple stages of awareness, exploration, expression, and identity integration (Bockting & Coleman, 2007; A. H. Devor, 2004; Vanderburgh, 2007). Similarly, a person's sexual orientation may progress through multiple stages of awareness, exploration, and identity through adolescence and into adulthood (Bilodeau & Renn, 2005). Just as some people experience their sexual orientation as being fluid or variable (L. M. Diamond, 2013), some people also experience their gender identity as fluid (Lev, 2004).

The experience of questioning one's gender can create significant confusion for some TGNC people, especially for those who are unfamiliar with the range of gender identities that exist. To explain any discordance they may experience between their sex assigned at birth, related societal expectations, patterns of sexual and romantic attraction, and/or gender role nonconformity and gender identity, some TGNC people may assume that they must be gay, lesbian, bisexual, or queer (Bockting, Benner, & Coleman, 2009). Focusing solely on sexual orientation as the cause for discordance may obscure awareness of a TGNC identity. It can be very important to include sexual orientation and gender identity in the process of identity exploration as well as in the associated decisions about which options will work best for any particular person. In addition, many TGNC adults have disguised or rejected their experience of gender incongruence in childhood or adolescence to conform to societal expectations and minimize their fear of difference (Bockting & Coleman, 2007; Byne et al., 2012).

Because gender and patterns of attraction are used to identify a person's sexual orientation, the articulation of sexual orientation is made more complex when sex assigned at birth is not aligned with gender identity. A person's sexual orientation identity cannot be determined by simply examining external appearance or behavior, but must incorporate a person's identity and self-identification (Broido, 2000).

Application. Psychologists may assist people in differentiating gender identity and sexual orientation. As clients become aware of previously hidden or constrained aspects of their gender identity or sexuality, psychologists may provide acceptance, support, and understanding without making assumptions or imposing a specific sexual orientation or gender identity outcome (APA TFGIGV, 2009). Because of their roles in assessment, treatment, and prevention, psychologists are in a unique position to help TGNC people better understand and integrate the various aspects of their identities. Psychologists may assist TGNC people by introducing and normalizing differences in gender identity and expression. As a TGNC person finds a

comfortable way to actualize and express their gender identity, psychologists may notice that previously incongruent aspects of their sexual orientation may become more salient, better integrated, or increasingly egosyntonic (Bockting et al., 2009; H. Devor, 1993; Schleifer, 2006). This process may allow TGNC people the comfort and opportunity to explore attractions or aspects of their sexual orientation that previously had been repressed, hidden, or in conflict with their identity. TGNC people may experience a renewed exploration of their sexual orientation, a widened spectrum of attraction, or a shift in how they identify their sexual orientation in the context of a developing TGNC identity (Coleman, Bockting, & Gooren, 1993; Meier, Pardo, Labuski, & Babcock, 2013; Samons, 2008).

Psychologists may need to provide TGNC people with information about TGNC identities, offering language to describe the discordance and confusion TGNC people may be experiencing. To facilitate TGNC people's learning, psychologists may introduce some of the narratives written by TGNC people that reflect a range of outcomes and developmental processes in exploring and affirming gender identity (e.g., Bornstein & Bergman, 2010; Boylan, 2013; J. Green, 2004; Krieger, 2011; Lawrence, 2014). These resources may potentially aid TGNC people in distinguishing between issues of sexual orientation and gender identity and in locating themselves on the gender spectrum. Psychologists may also educate families and broader community systems (e.g., schools, medical systems) to better understand how gender identity and sexual orientation are different but related; this may be particularly useful when working with youth (Singh & Burnes, 2009; Whitman, 2013). Because gender identity and sexual orientation are often conflated, even by professionals, psychologists are encouraged to carefully examine resources that claim to provide affirmative services for lesbian, gay, bisexual, transgender, and queer (LGBTQ) people, and to confirm which are knowledgeable about and inclusive of the needs of TGNC people before offering referrals or recommendations to TGNC people and their families.

Guideline 3. Psychologists seek to understand how gender identity intersects with the other cultural identities of TGNC people.

Rationale. Gender identity and gender expression may have profound intersections with other aspects of identity (Collins, 2000; Warner, 2008). These aspects may include, but are not limited to, race/ethnicity, age, education, socioeconomic status, immigration status, occupation, disability status, HIV status, sexual orientation, relational status, and religion and/or spiritual affiliation. Whereas some of these aspects of identity may afford privilege, others may create stigma and hinder empowerment (Burnes & Chen, 2012; K. M. de Vries, 2015). In addition, TGNC people who transition may not be prepared for changes in privilege or societal treatment based on gender identity and gender expression. To illustrate, an African American trans man may gain male privilege, but may face racism and

societal stigma particular to African American men. An Asian American/Pacific Islander trans woman may experience the benefit of being perceived as a cisgender woman, but may also experience sexism, misogyny, and objectification particular to Asian American/Pacific Islander cisgender women.

The intersection of multiple identities within TGNC people's lives is complex and may obstruct or facilitate access to necessary support (A. Daley, Solomon, Newman, & Mishna, 2008). TGNC people with less privilege and/or multiple oppressed identities may experience greater stress and restricted access to resources. They may also develop resilience and strength in coping with disadvantages, or may locate community-based resources available to specific groups (e.g., for people living with HIV; Singh et al., 2011). Gender identity affirmation may conflict with religious beliefs or traditions (Bockting & Cesaretti, 2001). Finding an affirmative expression of their religious and spiritual beliefs and traditions, including positive relationships with religious leaders, can be an important resource for TGNC people (Glaser, 2008; Porter, Ronneberg, & Witten, 2013; Xavier, 2000).

Application. In practice, psychologists strive to recognize the salient multiple and intersecting identities of TGNC people that influence coping, discrimination, and resilience (Burnes & Chen, 2012). Improved rapport and therapeutic alliance are likely to develop when psychologists avoid overemphasizing gender identity and gender expression when not directly relevant to TGNC people's needs and concerns. Even when gender identity is the main focus of care, psychologists are encouraged to understand that a TGNC person's experience of gender may also be shaped by other important aspects of identity (e.g., age, race/ethnicity, sexual orientation), and that the salience of different aspects of identity may evolve as the person continues psychosocial development across the life span, regardless of whether they complete a social or medical transition.

At times, a TGNC person's intersection of identities may result in conflict, such as a person's struggle to integrate gender identity with religious and/or spiritual upbringing and beliefs (Kidd & Witten, 2008; Levy & Lo, 2013; Rodriguez & Follins, 2012). Psychologists may aid TGNC people in understanding and integrating identities that may be differently privileged within systems of power and systemic inequity (Burnes & Chen, 2012). Psychologists may also highlight and strengthen the development of TGNC people's competencies and resilience as they learn to manage the intersection of stigmatized identities (Singh, 2012).

Guideline 4. Psychologists are aware of how their attitudes about and knowledge of gender identity and gender expression may affect the quality of care they provide to TGNC people and their families.

Rationale. Psychologists, like other members of society, come to their personal understanding and acceptance of different aspects of human diversity through a

process of socialization. Psychologists' cultural biases, as well as the cultural differences between psychologists and their clients, have a clinical impact (Israel, Gorcheva, Burnes, & Walther, 2008; Vasquez, 2007). The assumptions, biases, and attitudes psychologists hold regarding TGNC people and gender identity and/or gender expression can affect the quality of services psychologists provide and their ability to develop an effective therapeutic alliance (Bess & Stabb, 2009; Rachlin, 2002). In addition, a lack of knowledge or training in providing affirmative care to TGNC people can limit a psychologist's effectiveness and perpetuate barriers to care (Bess & Stabb, 2009; Rachlin, 2002). Psychologists experienced with lesbian, gay, or bisexual (LGB) people may not be familiar with the unique needs of TGNC people (Israel, 2005; Israel et al., 2008). In community surveys, TGNC people have reported that many mental health care providers lack basic knowledge and skills relevant to care of TGNC people (Bradford, Xavier, Hendricks, Rives, & Honnold, 2007; Xavier, Bobbin, Singer, & Budd, 2005) and receive little training to prepare them to work with TGNC people (APA TFGIGV, 2009; Lurie, 2005). The National Transgender Discrimination Survey (Grant et al., 2011) reported that 50% of TGNC respondents shared that they had to educate their health care providers about TGNC care, 28% postponed seeking medical care due to antitrans bias, and 19% were refused care due to discrimination.

The APA ethics code (APA, 2010) specifies that psychologists practice in areas only within the boundaries of their competence (Standard 2.01), participate in proactive and consistent ways to enhance their competence (Standard 2.03), and base their work upon established scientific and professional knowledge (Standard 2.04). Competence in working with TGNC people can be developed through a range of activities, such as education, training, supervised experience, consultation, study, or professional experience.

Application. Psychologists may engage in practice with TGNC people in various ways; therefore, the depth and level of knowledge and competence required by a psychologist depends on the type and complexity of service offered to TGNC people. Services that psychologists provide to TGNC people require a basic understanding of the population and its needs, as well as the ability to respectfully interact in a trans-affirmative manner (L. Carroll, 2010).

APA emphasizes the use of evidence-based practice (APA Presidential Task Force on Evidence-Based Practice, 2006). Given how easily assumptions or stereotypes could influence treatment, evidence-based practice may be especially relevant to psychological practice with TGNC people. Until evidence-based practices are developed specifically for TGNC people, psychologists are encouraged to utilize existing evidence-based practices in the care they provide. APA also promotes collaboration with clients concerning clinical decisions, including issues related to costs, potential benefits, and the existing options and resources related to treatment (APA Presidential Task Force on Evidence-Based Practice, 2006). TGNC people could benefit from such collaboration and active engagement in decision

making, given the historical disenfranchisement and disempowerment of TGNC people in health care.

In an effort to develop competence in working with TGNC people, psychologists are encouraged to examine their personal beliefs regarding gender and sexuality, gender stereotypes, and TGNC identities, in addition to identifying gaps in their own knowledge, understanding, and acceptance (American Counseling Association [ACA], 2010). This examination may include exploring one's own gender identity and gendered experiences related to privilege, power, or marginalization, as well as seeking consultation and training with psychologists who have expertise in working with TGNC people and communities.

Psychologists are further encouraged to develop competence in working with TGNC people and their families by seeking up-to-date basic knowledge and understanding of gender identity and expression, and learning how to interact with TGNC people and their families respectfully and without judgment. Competence in working with TGNC people may be achieved and maintained in formal and informal ways, ranging from exposure in the curriculum of training programs for future psychologists and continuing education at professional conferences, to affirmative involvement as allies in the TGNC community. Beyond acquiring general competence, psychologists who choose to specialize in working with TGNC people presenting with gender-identity-related concerns are strongly encouraged to obtain advanced training, consultation, and professional experience (ACA, 2010; Coleman et al., 2012).

Psychologists may gain knowledge about the TGNC community and become more familiar with the complex social issues that affect the lives of TGNC people through first-hand experiences (e.g., attending community meetings and conferences, reading narratives written by TGNC people). If psychologists have not yet developed competence in working with TGNC people, it is recommended that they refer TGNC people to other psychologists or providers who are knowledgeable and able to provide trans-affirmative care.

Stigma, Discrimination, and Barriers to Care

Guideline 5. Psychologists recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people.

Rationale. Many TGNC people experience discrimination, ranging from subtle to severe, when accessing housing, health care, employment, education, public assistance, and other social services (Bazargan & Galvan, 2012; Bradford, Reisner, Honnold, & Xavier, 2013; Dispenza, Watson, Chung, & Brack, 2012; Grant et al., 2011). Discrimination can include assuming a person's assigned sex at birth is fully aligned with that person's gender identity, not using a person's preferred name or pronoun, asking TGNC people inappropriate questions about their bodies, or making the assumption that psychopathology exists given a specific gender identity or gender expression (Na-

dal, Rivera, & Corpus, 2010; Nadal, Skolnik, & Wong, 2012). Discrimination may also include refusing access to housing or employment or extreme acts of violence (e.g., sexual assault, murder). TGNC people who hold multiple marginalized identities are more vulnerable to discrimination and violence. TGNC women and people of color disproportionately experience severe forms of violence and discrimination, including police violence, and are less likely to receive help from law enforcement (Edelman, 2011; National Coalition of Anti-Violence Programs, 2011; Saffin, 2011).

TGNC people are at risk of experiencing antitrans prejudice and discrimination in educational settings. In a national representative sample of 7,898 LGBT youth in K-12 settings, 55.2% of participants reported verbal harassment, 22.7% reported physical harassment, and 11.4% reported physical assault based on their gender expression (Kosciw, Greytak, Palmer, & Boesen, 2014). In a national community survey of TGNC adults, 15% reported prematurely leaving educational settings ranging from kindergarten through college as a result of harassment (Grant et al., 2011). Many schools do not include gender identity and gender expression in their school nondiscrimination policies; this leaves TGNC youth without needed protections from bullying and aggression in schools (Singh & Jackson, 2012). TGNC youth in rural settings may be even more vulnerable to bullying and hostility in their school environments due to antitrans prejudice (Kosciw et al., 2014).

Inequities in educational settings and other forms of TGNC-related discrimination may contribute to the significant economic disparities TGNC people have reported. Grant and colleagues (2011) found that TGNC people were four times more likely to have a household income of less than \$10,000 compared with cisgender people, and almost half of a sample of TGNC older adults reported a household income at or below 200% of poverty (Fredriksen-Goldsen et al., 2014). TGNC people often face workplace discrimination both when seeking and maintaining employment (Brewster, Velez, Mennicke, & Tebbe, 2014; Dispenza et al., 2012; Mizock & Mueser, 2014). In a nonrepresentative national study of TGNC people, 90% reported having "directly experienced harassment or mistreatment at work and felt forced to take protective actions that negatively impacted their careers or their well-being, such as hiding who they were to avoid workplace repercussions" (Grant et al., 2011, p. 56). In addition, 78% of respondents reported experiencing some kind of direct mistreatment or discrimination at work (Grant et al., 2011). Employment discrimination may be related to stigma based on a TGNC person's appearance, discrepancies in identity documentation, or being unable to provide job references linked to that person's pretransition name or gender presentation (Bender-Baird, 2011).

Issues of employment discrimination and workplace harassment are particularly salient for TGNC military personnel and veterans. Currently, TGNC people cannot serve openly in the U.S. military. Military regulations cite "transsexualism" as a medical exclusion from service (Department of Defense, 2011; Elders & Steinman, 2014). When

enlisted, TGNC military personnel are faced with very difficult decisions related to coming out, transition, and seeking appropriate medical and mental health care, which may significantly impact or end their military careers. Not surprisingly, research documents very high rates of suicidal ideation and behavior among TGNC military and veteran populations (Blosnich et al., 2013; Matarazzo et al., 2014). Being open about their TGNC identity with health care providers can carry risk for TGNC military personnel (Out-Serve-Servicemembers Legal Defense Network, n.d.). Barriers to accessing health care noted by TGNC veterans include viewing the VA health care system as an extension of the military, perceiving the VA as an unwelcoming environment, and fearing providers' negative reactions to their identity (Sherman, Kauth, Shipherd, & Street, 2014; Shipherd, Mizock, Maguen, & Green, 2012). A recent study shows 28% of LGBT veterans perceived their VA as welcoming and one third as unwelcoming (Sherman et al., 2014). Multiple initiatives are underway throughout the VA system to improve the quality and sensitivity of services to LGBT veterans.

Given widespread workplace discrimination and possible dismissal following transition, TGNC people may engage in sex work or survival sex (e.g., trading sex for food), or sell drugs to generate income (Grant et al., 2011; Hwang & Nuttbrock, 2007; Operario, Soma, & Underhill, 2008; Stanley, 2011). This increases the potential for negative interactions with the legal system, such as harassment by the police, bribery, extortion, and arrest (Edelman, 2011; Testa et al., 2012), as well as increased likelihood of mental health symptoms and greater health risks, such as higher incidence of sexually transmitted infections, including HIV (Nemoto, Operario, Keatley, & Villegas, 2004).

Incarcerated TGNC people report harassment, isolation, forced sex, and physical assault, both by prison personnel and other inmates (American Civil Liberties Union National Prison Project, 2005; Brothman, 2013; C. Daley, 2005). In sex-segregated facilities, TGNC people may be subjected to involuntary solitary confinement (also called "administrative segregation"), which can lead to severe negative mental and physical health consequences and may block access to services (Gallagher, 2014; National Center for Transgender Equality, 2012). Another area of concern is for TGNC immigrants and refugees. TGNC people in detention centers may not be granted access to necessary care and experience significant rates of assault and violence in these facilities (Gruberg, 2013). TGNC people may seek asylum in the United States to escape danger as a direct result of lack of protections in their country of origin (APA Presidential Task Force on Immigration, 2012; Cerezo, Morales, Quintero, & Rothman, 2014; Morales, 2013).

TGNC people have difficulty accessing necessary health care (Fredriksen-Goldsen et al., 2014; Lambda Legal, 2012) and often feel unsafe sharing their gender identity or their experiences of antitrans prejudice and discrimination due to historical and current discrimination from health care providers (Grant et al., 2011; Lurie, 2005; Singh & McKleroy, 2011). Even when TGNC people have health insurance, plans may explicitly exclude coverage

related to gender transition (e.g., hormone therapy, surgery). TGNC people may also have difficulty accessing trans-affirmative primary health care if coverage for procedures is denied based on gender. For example, trans men may be excluded from necessary gynecological care based on the assumption that men do not need these services. These barriers often lead to a lack of preventive health care for TGNC people (Fredriksen-Goldsen et al., 2014; Lambda Legal, 2012). Although the landscape is beginning to change with the recent revision of Medicare policy (National Center for Transgender Equality, 2014) and changes to state laws (Transgender Law Center, n.d.), many TGNC people are still likely to have little to no access to TGNC-related health care as a result of the exclusions in their insurance.

Application. Awareness of and sensitivity to the effects of antitrans prejudice and discrimination can assist psychologists in assessing, treating, and advocating for their TGNC clients. When a TGNC person faces discrimination based on gender identity or gender expression, psychologists may facilitate emotional processing of these experiences and work with the person to identify supportive resources and possible courses of action. Specific needs of TGNC people might vary from developing self-advocacy strategies, to navigating public spaces, to seeking legal recourse for harassment and discrimination in social services and other systems. Additionally, TGNC people who have been traumatized by physical or emotional violence may need therapeutic support.

Psychologists may be able to assist TGNC people in accessing relevant social service systems. For example, psychologists may be able to assist in identifying health care providers and housing resources that are affirming and affordable, or locating affirming religious and spiritual communities (Glaser, 2008; Porter et al., 2013). Psychologists may also assist in furnishing documentation or official correspondence that affirms gender identity for the purpose of accessing appropriate public accommodations, such as bathroom use or housing (Lev, 2009; W. J. Meyer, 2009).

Additionally, psychologists may identify appropriate resources, information, and services to help TGNC people in addressing workplace discrimination, including strategies during a social and/or medical transition for identity disclosure at work. For those who are seeking employment, psychologists may help strategize about how and whether to share information about gender history. Psychologists may also work with employers to develop supportive policies for workplace gender transition or to develop training to help employees adjust to the transition of a coworker.

For TGNC military and veteran populations, psychologists may help to address the emotional impact of navigating TGNC identity development in the military system. Psychologists are encouraged to be aware that issues of confidentiality may be particularly sensitive with active duty or reserve status service members, as the consequences of being identified as TGNC may prevent the client's disclosure of gender identity in treatment.

In educational settings, psychologists may advocate for TGNC youth on a number of levels (APA & National

Association of School Psychologists, 2014; Boulder Valley School District, 2012). Psychologists may consult with administrators, teachers, and school counselors to provide resources and trainings on antitrans prejudice and developing safer school environments for TGNC students (Singh & Burnes, 2009). Peer support from other TGNC people has been shown to buffer the negative effect of stigma on mental health (Bockting et al., 2013). As such, psychologists may consider and develop peer-based interventions to facilitate greater understanding and respectful treatment of TGNC youth by cisgender peers (Case & Meier, 2014). Psychologists may work with TGNC youth and their families to identify relevant resources, such as school policies that protect gender identity and gender expression (APA & National Association of School Psychologists, 2014; Gonzalez & McNulty, 2010), referrals to TGNC-affirmative organizations, and online resources, which may be especially helpful for TGNC youth in rural settings.

Guideline 6. Psychologists strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-affirmative environments.

Rationale. Antitrans prejudice and the adherence of mainstream society to the gender binary adversely affect TGNC people within their families, schools, health care, legal systems, workplaces, religious traditions, and communities (American Civil Liberties Union National Prison Project, 2005; Bradford et al., 2013; Brewster et al., 2014; Levy & Lo, 2013; McGuire, Anderson, & Toomey, 2010). TGNC people face challenges accessing gender-inclusive restrooms, which may result in discomfort when being forced to use a men's or women's restroom (Transgender Law Center, 2005). In addition to the emotional distress the forced binary choice that public restrooms may create for some, TGNC people are frequently concerned with others' reactions to their presence in public restrooms, including potential discrimination, harassment, and violence (Herman, 2013).

Many TGNC people may be distrustful of care providers due to previous experiences of being pathologized (Benson, 2013). Experiences of discrimination and prejudice with health care providers may be complicated by power differentials within the therapeutic relationship that may greatly affect or complicate the care that TGNC people experience. TGNC people have routinely been asked to obtain an endorsement letter from a psychologist attesting to the stability of their gender identity as a prerequisite to access an endocrinologist, surgeon, or legal institution (e.g., driver's license bureau; Lev, 2009). The need for such required documentation from a psychologist may influence rapport, resulting in TGNC people fearing prejudicial treatment in which this documentation is withheld or delayed by the treating provider (Bouman et al., 2014). Whether a TGNC person has personally experienced interactions with providers as disempowering or has learned from community members to expect such a dynamic, psychologists are encouraged to be prepared for TGNC people to be very cautious when entering into a therapeutic rela-

tionship. When TGNC people feel validated and empowered within the environment in which a psychologist practices, the therapeutic relationship will benefit and the person may be more willing to explore their authentic selves and share uncertainties and ambiguities that are a common part of TGNC identity development.

Application. Because many TGNC people experience antitrans prejudice or discrimination, psychologists are encouraged to ensure that their work settings are welcoming and respectful of TGNC people, and to be mindful of what TGNC people may perceive as unwelcoming. To do so, psychologists may educate themselves about the many ways that cisgender privilege and antitrans prejudice may be expressed. Psychologists may also have specific conversations with TGNC people about their experiences of the mental health system and implement feedback to foster TGNC-affirmative environments. As a result, when TGNC people access various treatment settings and public spaces, they may experience less harm, disempowerment, or pathologization, and thus will be more likely to avail themselves of resources and support.

Psychologists are encouraged to be proactive in considering how overt or subtle cues in their workplaces and other environments may affect the comfort and safety of TGNC people. To increase the comfort of TGNC people, psychologists are encouraged to display TGNC-affirmative resources in waiting areas and to avoid the display of items that reflect antitrans attitudes (Lev, 2009). Psychologists are encouraged to examine how their language (e.g., use of incorrect pronouns and names) may reinforce the gender binary in overt or subtle and unintentional ways (Smith, Shin, & Officer, 2012). It may be helpful for psychologists to provide training for support staff on how to respectfully interact with TGNC people. A psychologist may consider making changes to paperwork, forms, or outreach materials to ensure that these materials are more inclusive of TGNC people (Spade, 2011b). For example, demographic questionnaires can communicate respect through the use of inclusive language and the inclusion of a range of gender identities. In addition, psychologists may also work within their institutions to advocate for restrooms that are inclusive and accessible for people of all gender identities and/or gender expressions.

When working with TGNC people in a variety of care and institutional settings (e.g., inpatient medical and psychiatric hospitals, substance abuse treatment settings, nursing homes, foster care, religious communities, military and VA health care settings, and prisons), psychologists may become liaisons and advocates for TGNC people's mental health needs and for respectful treatment that addresses their gender identity in an affirming manner. In playing this role, psychologists may find guidance and best practices that have been published for particular institutional contexts to be helpful (e.g., Department of Veterans Affairs, Veterans' Health Administration, 2013; Glezer, McNeil, & Binder, 2013; Merksamer, 2011).

Guideline 7: Psychologists understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people.

Rationale. The lack of public policy that addresses the needs of TGNC people creates significant hardships for them (Taylor, 2007). Although there have been major advances in legal protections for TGNC people in recent years (Buzuvis, 2013; Harvard Law Review Association, 2013), many TGNC people are still not afforded protections from discrimination on the basis of gender identity or expression (National LGBTQ Task Force, 2013; Taylor, 2007). For instance, in many states, TGNC people do not have employment or housing protections and may be fired or lose their housing based on their gender identity. Many policies that protect the rights of cisgender people, including LGB people, do not protect the rights of TGNC people (Currah, & Minter, 2000; Spade, 2011a).

TGNC people can experience challenges obtaining gender-affirming identity documentation (e.g., birth certificate, passport, social security card, driver's license). For TGNC people experiencing poverty or economic hardship, requirements for obtaining this documentation may be impossible to meet, in part due to the difficulty of securing employment without identity documentation that aligns with their gender identity and gender expression (Sheridan, 2009). Additionally, systemic barriers related to binary gender identification systems prevent some TGNC people from changing their documents, including those who are incarcerated, undocumented immigrants, and people who live in jurisdictions that explicitly forbid such changes (Spade, 2006). Documentation requirements can also assume a universal TGNC experience that marginalizes some TGNC people, especially those who do not undergo a medical transition. This may affect a TGNC person's social and psychological well-being and interfere with accessing employment, education, housing and shelter, health care, public benefits, and basic life management resources (e.g., opening a bank account).

Application. Psychologists are encouraged to inform public policy to reduce negative systemic impact on TGNC people and to promote positive social change. Psychologists are encouraged to identify and improve systems that permit violence; educational, employment, and housing discrimination; lack of access to health care; unequal access to other vital resources; and other instances of systemic inequity that TGNC people experience (ACA, 2010). Many TGNC people experience stressors from constant barriers, inequitable treatment, and forced release of sensitive and private information about their bodies and their lives (Hendricks & Testa, 2012). To obtain proper identity documentation, TGNC people may be required to provide court orders, proof of having had surgery, and documentation of psychotherapy or a psychiatric diagnosis. Psychologists may assist TGNC people by normalizing their reactions of fatigue and traumatization while interacting with legal systems and requirements; TGNC people may also benefit from guidance about alternate avenues of

recourse, self-advocacy, or appeal. When TGNC people feel that it is unsafe to advocate for themselves, psychologists may work with their clients to access appropriate resources in the community.

Psychologists are encouraged to be sensitive to the challenges of attaining gender-affirming identity documentation and how the receipt or denial of such documentation may affect social and psychological well-being, the person's ability to obtain education and employment, find safe housing, access public benefits, obtain student loans, and access health insurance. It may be of significant assistance for psychologists to understand and offer information about the process of a legal name change, gender marker change on identification, or the process for accessing other gender-affirming documents. Psychologists may consult the National Center for Transgender Equality, the Sylvia Rivera Law Project, or the Transgender Law Center for additional information on identity documentation for TGNC people.

Psychologists may choose to become involved with an organization that seeks to revise law and public policy to better protect the rights and dignities of TGNC people. Psychologists may participate at the local, state, or national level to support TGNC-affirmative health care accessibility, human rights in sex-segregated facilities, or policy change regarding gender-affirming identity documentation. Psychologists working in institutional settings may also expand their roles to work as collaborative advocates for TGNC people (Gonzalez & McNulty, 2010). Psychologists are encouraged to provide written affirmations supporting TGNC people and their gender identity so that they may access necessary services (e.g., hormone therapy).

Life Span Development

Guideline 8. Psychologists working with gender-questioning⁴ and TGNC youth understand the different developmental needs of children and adolescents, and that not all youth will persist in a TGNC identity into adulthood.

Rationale. Many children develop stability (constancy across time) in their gender identity between Ages 3 to 4 (Kohlberg, 1966), although gender consistency (recognition that gender remains the same across situations) often does not occur until Ages 4 to 7 (Siegal & Robinson, 1987). Children who demonstrate gender nonconformity in preschool and early elementary years may not follow this trajectory (Zucker & Bradley, 1995). Existing research suggests that between 12% and 50% of children diagnosed with gender dysphoria may persist in their identification with a gender different than sex assigned at birth into late adolescence and young adulthood (Drummond, Bradley,

⁴ Gender-questioning youth are differentiated from TGNC youth in this section of the guidelines. Gender-questioning youth may be questioning or exploring their gender identity but have not yet developed a TGNC identity. As such, they may not be eligible for some services that would be offered to TGNC youth. Gender-questioning youth are included here because gender questioning may lead to a TGNC identity.

Peterson-Badaali, & Zucker, 2008; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). However, several research studies categorized 30% to 62% of youth who did not return to the clinic for medical intervention after initial assessment, and whose gender identity may be unknown, as “desisters” who no longer identified with a gender different than sex assigned at birth (Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008; Zucker, 2008a). As a result, this research runs a strong risk of inflating estimates of the number of youth who do not persist with a TGNC identity. Research has suggested that children who identify more intensely with a gender different than sex assigned at birth are more likely to persist in this gender identification into adolescence (Steensma et al., 2013), and that when gender dysphoria persists through childhood and intensifies into adolescence, the likelihood of long-term TGNC identification increases (A. L. de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2011; Steensma et al., 2013; Wallien & Cohen-Kettenis, 2008; Zucker, 2008b). Gender-questioning children who do not persist may be more likely to later identify as gay or lesbian than non-gender-questioning children (Bailey & Zucker, 1995; Drescher, 2014; Wallien & Cohen-Kettenis, 2008).

A clear distinction between care of TGNC and gender-questioning children and adolescents exists in the literature. Due to the evidence that not all children persist in a TGNC identity into adolescence or adulthood, and because no approach to working with TGNC children has been adequately, empirically validated, consensus does not exist regarding best practice with prepubertal children. Lack of consensus about the preferred approach to treatment may be due in part to divergent ideas regarding what constitutes optimal treatment outcomes for TGNC and gender-questioning youth (Hembree et al., 2009). Two distinct approaches exist to address gender identity concerns in children (Hill, Menvielle, Sica, & Johnson, 2010; Wallace & Russell, 2013), with some authors subdividing one of the approaches to suggest three (Byne et al., 2012; Drescher, 2014; Stein, 2012).

One approach encourages an affirmation and acceptance of children’s expressed gender identity. This may include assisting children to socially transition and to begin medical transition when their bodies have physically developed, or allowing a child’s gender identity to unfold without expectation of a specific outcome (A. L. de Vries & Cohen-Kettenis, 2012; Edwards-Leeper & Spack, 2012; Ehrensaft, 2012; Hidalgo et al., 2013; Tishelman et al., 2015). Clinicians using this approach believe that an open exploration and affirmation will assist children to develop coping strategies and emotional tools to integrate a positive TGNC identity should gender questioning persist (Edwards-Leeper & Spack, 2012).

In the second approach, children are encouraged to embrace their given bodies and to align with their assigned gender roles. This includes endorsing and supporting behaviors and attitudes that align with the child’s sex assigned at birth prior to the onset of puberty (Zucker, 2008a; Zucker, Wood, Singh, & Bradley, 2012). Clinicians using

this approach believe that undergoing multiple medical interventions and living as a TGNC person in a world that stigmatizes gender nonconformity is a less desirable outcome than one in which children may be assisted to happily align with their sex assigned at birth (Zucker et al., 2012). Consensus does not exist regarding whether this approach may provide benefit (Zucker, 2008a; Zucker et al., 2012) or may cause harm or lead to psychosocial adversities (Hill et al., 2010; Pyne, 2014; Travers et al., 2012; Wallace & Russell, 2013). When addressing psychological interventions for children and adolescents, the World Professional Association for Transgender Health Standards of Care identify interventions “aimed at trying to change gender identity and expression to become more congruent with sex assigned at birth” as unethical (Coleman et al., 2012, p. 175). It is hoped that future research will offer improved guidance in this area of practice (Adelson & AACAP CQI, 2012; Malpas, 2011).

Much greater consensus exists regarding practice with adolescents. Adolescents presenting with gender identity concerns bring their own set of unique challenges. This may include having a late-onset (i.e., postpubertal) presentation of gender nonconforming identification, with no history of gender role nonconformity or gender questioning in childhood (Edwards-Leeper & Spack, 2012). Complicating their clinical presentation, many gender-questioning adolescents also present with co-occurring psychological concerns, such as suicidal ideation, self-injurious behaviors (Liu & Mustanski, 2012; Mustanski, Garofalo, & Emerson, 2010), drug and alcohol use (Garofalo et al., 2006), and autism spectrum disorders (A. L. de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers, 2010; Jones et al., 2012). Additionally, adolescents can become intensely focused on their immediate desires, resulting in outward displays of frustration and resentment when faced with any delay in receiving the medical treatment from which they feel they would benefit and to which they feel entitled (Angello, 2013; Edwards-Leeper & Spack, 2012). This intense focus on immediate needs may create challenges in assuring that adolescents are cognitively and emotionally able to make life-altering decisions to change their name or gender marker, begin hormone therapy (which may affect fertility), or pursue surgery.

Nonetheless, there is greater consensus that treatment approaches for adolescents affirm an adolescents’ gender identity (Coleman et al., 2012). Treatment options for adolescents extend beyond social approaches to include medical approaches. One particular medical intervention involves the use of puberty-suppressing medication or “blockers” (GnRH analogue), which is a reversible medical intervention used to delay puberty for appropriately screened adolescents with gender dysphoria (Coleman et al., 2012; A. L. C. de Vries et al., 2014; Edwards-Leeper, & Spack, 2012). Because of their age, other medical interventions may also become available to adolescents, and psychologists are frequently consulted to provide an assessment of whether such procedures would be advisable (Coleman et al., 2012).

Application. Psychologists working with TGNC and gender-questioning youth are encouraged to regularly review the most current literature in this area, recognizing the limited available research regarding the potential benefits and risks of different treatment approaches for children and for adolescents. Psychologists are encouraged to offer parents and guardians clear information about available treatment approaches, regardless of the specific approach chosen by the psychologist. Psychologists are encouraged to provide psychological service to TGNC and gender-questioning children and adolescents that draws from empirically validated literature when available, recognizing the influence psychologists' values and beliefs may have on the treatment approaches they select (Ehrbar & Gorton, 2010). Psychologists are also encouraged to remain aware that what one youth and/or parent may be seeking in a therapeutic relationship may not coincide with a clinician's approach (Brill & Pepper, 2008). In cases in which a youth and/or parent identify different preferred treatment outcomes than a clinician, it may not be clinically appropriate for the clinician to continue working with the youth and family, and alternative options, including referral, might be considered. Psychologists may also find themselves navigating family systems in which youth and their caregivers are seeking different treatment outcomes (Edwards-Leeper & Spack, 2012). Psychologists are encouraged to carefully reflect on their personal values and beliefs about gender identity development in conjunction with the available research, and to keep the best interest of the child or adolescent at the forefront of their clinical decisions at all times.

Because gender nonconformity may be transient for younger children in particular, the psychologist's role may be to help support children and their families through the process of exploration and self-identification (Ehrensaft, 2012). Additionally, psychologists may provide parents with information about possible long-term trajectories children may take in regard to their gender identity, along with the available medical interventions for adolescents whose TGNC identification persists (Edwards-Leeper & Spack, 2012).

When working with adolescents, psychologists are encouraged to recognize that some TGNC adolescents will not have a strong history of childhood gender role nonconformity or gender dysphoria either by self-report or family observation (Edwards-Leeper & Spack, 2012). Some of these adolescents may have withheld their feelings of gender nonconformity out of a fear of rejection, confusion, conflating gender identity and sexual orientation, or a lack of awareness of the option to identify as TGNC. Parents of these adolescents may need additional assistance in understanding and supporting their youth, given that late-onset gender dysphoria and TGNC identification may come as a significant surprise. Moving more slowly and cautiously in these cases is often advisable (Edwards-Leeper & Spack, 2012). Given the possibility of adolescents' intense focus on immediate desires and strong reactions to perceived delays or barriers, psychologists are encouraged to validate these concerns and the desire to move through the process

quickly while also remaining thoughtful and deliberate in treatment. Adolescents and their families may need support in tolerating ambiguity and uncertainty with regard to gender identity and its development (Brill & Pepper, 2008). It is encouraged that care should be taken not to foreclose this process.

For adolescents who exhibit a long history of gender nonconformity, psychologists may inform parents that the adolescent's self-affirmed gender identity is most likely stable (A. L. de Vries et al., 2011). The clinical needs of these adolescents may be different than those who are in the initial phases of exploring or questioning their gender identity. Psychologists are encouraged to complete a comprehensive evaluation and ensure the adolescent's and family's readiness to progress while also avoiding unnecessary delay for those who are ready to move forward.

Psychologists working with TGNC and gender-questioning youth are encouraged to become familiar with medical treatment options for adolescents (e.g., puberty-suppressing medication, hormone therapy) and work collaboratively with medical providers to provide appropriate care to clients. Because the ongoing involvement of a knowledgeable mental health provider is encouraged due to the psychosocial implications, and is often also a required part of the medical treatment regimen that may be offered to TGNC adolescents (Coleman et al., 2012; Hembree et al., 2009), psychologists often play an essential role in assisting in this process.

Psychologists may encourage parents and caregivers to involve youth in developmentally appropriate decision making about their education, health care, and peer networks, as these relate to children's and adolescents' gender identity and gender expression (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). Psychologists are also encouraged to educate themselves about the advantages and disadvantages of social transition during childhood and adolescence, and to discuss these factors with both their young clients and clients' parents. Emphasizing to parents the importance of allowing their child the freedom to return to a gender identity that aligns with sex assigned at birth or another gender identity at any point cannot be overstated, particularly given the research that suggests that not all young gender nonconforming children will ultimately express a gender identity different from that assigned at birth (Wallien, & Cohen-Kettenis, 2008; Zucker & Bradley, 1995). Psychologists are encouraged to acknowledge and explore the fear and burden of responsibility that parents and caregivers may feel as they make decisions about the health of their child or adolescent (Grossman, D'Augelli, Howell, & Hubbard, 2006). Parents and caregivers may benefit from a supportive environment to discuss feelings of isolation, explore loss and grief they may experience, vent anger and frustration at systems that disrespect or discriminate against them and their youth, and learn how to communicate with others about their child's or adolescent's gender identity or gender expression (Brill & Pepper, 2008).

Guideline 9. Psychologists strive to understand both the particular challenges that TGNC elders experience and the resilience they can develop.

Rationale. Little research has been conducted about TGNC elders, leaving much to be discovered about this life stage for TGNC people (Auldrige, Tamar-Mattis, Kennedy, Ames, & Tobin, 2012). Socialization into gender role behaviors and expectations based on sex assigned at birth, as well as the extent to which TGNC people adhere to these societal standards, is influenced by the chronological age at which a person self-identifies as TGNC, the age at which a person comes out or socially and/or medically transitions (Birren & Schaie, 2006; Bockting & Coleman, 2007; Cavanaugh & Blanchard-Fields, 2010; Nuttbrock et al., 2010; Wahl, Iwarsson, & Oswald, 2012), and a person's generational cohort (e.g., 1950 vs. 2010; Fredriksen-Goldsen et al., 2011).

Even decades after a medical or social transition, TGNC elders may still subscribe to the predominant gender role expectations that existed at the time of their transition (Knochel, Croghan, Moore, & Quam, 2011). Prior to the 1980s, TGNC people who transitioned were strongly encouraged by providers to pass in society as cisgender and heterosexual and to avoid associating with other TGNC people (Benjamin, 1966; R. Green & Money, 1969; Hastings, 1974; Hastings & Markland, 1978). Even TGNC elders who were comfortable telling others about their TGNC identity when they were younger may choose not to reveal their identity at a later stage of life (Ekins & King, 2005; Ippolito & Witten, 2014). Elders' unwillingness to disclose their TGNC identity can result from feelings of physical vulnerability or increased reliance on others who may discriminate against them or treat them poorly as a result of their gender identity (Bockting & Coleman, 2007), especially if the elder resides in an institutionalized setting (i.e., nursing home, assisted living facility) and relies on others for many daily needs (Auldrige et al., 2012). TGNC elders are also at a heightened risk for depression, suicidal ideation, and loneliness compared with LGB elders (Auldrige et al., 2012; Fredriksen-Goldsen et al., 2011).

A Transgender Law Center survey found that TGNC and LGB elders had less financial well-being than their younger cohorts, despite having a higher than average educational level for their age group compared with the general population (Hartzell, Frazer, Wertz, & Davis, 2009). Survey research has also revealed that TGNC elders experience underemployment and gaps in employment, often due to discrimination (Auldrige et al., 2012; Beemyn & Rankin, 2011; Factor & Rothblum, 2007). In the past, some TGNC people with established careers may have been encouraged by service providers to find new careers or jobs to avoid undergoing a gender transition at work or being identified as TGNC, potentially leading to a significant loss of income and occupational identity (Cook-Daniels, 2006). Obstacles to employment can increase economic disparities that result in increased needs for supportive housing and other social services (National Center for

Transgender Equality, 2012; Services and Advocacy for GLBT Elders & National Center for Transgender Equality, 2012).

TGNC elders may face obstacles to seeking or accessing resources that support their physical, financial, or emotional well-being. For instance, they may be concerned about applying for social security benefits, fearing that their TGNC identity may become known (Hartzell et al., 2009). A TGNC elder may avoid medical care, increasing the likelihood of later needing a higher level of medical care (e.g., home-based care, assisted living, or nursing home) than their same-age cisgender peers (Hartzell et al., 2009; Ippolito & Witten, 2014; Mikalson et al., 2012). Nursing homes and assisted living facilities are rarely sensitive to the unique medical needs of TGNC elders (National Senior Citizens Law Center, 2011). Some TGNC individuals who enter congregate housing, assisted living, or long-term care settings may feel the need to reverse their transition to align with sex assigned at birth to avoid discrimination and persecution by other residents and staff (Ippolito & Witten, 2014).

Older age may both facilitate and complicate medical treatment related to gender transition. TGNC people who begin hormone therapy later in life may have a smoother transition due to waning hormone levels that are a natural part of aging (Witten & Eyler, 2012). Age may also influence the decisions TGNC elders make regarding sex-affirmation surgeries, especially if physical conditions exist that could significantly increase risks associated with surgery or recovery.

Much has been written about the resilience of elders who have endured trauma (Fuhrmann & Shevlowitz, 2006; Hardy, Concato, & Gill, 2004; Mlinac, Sheeran, Blissmer, Lees, & Martins, 2011; Rodin & Stewart, 2012). Although some TGNC elders have experienced significant psychological trauma related to their gender identity, some also have developed resilience and effective ways of coping with adversity (Fruhauf & Orel, 2015). Despite the limited availability of LGBTQ-affirmative religious organizations in many local communities, TGNC elders make greater use of these resources than their cisgender peers (Porter et al., 2013).

Application. Psychologists are encouraged to seek information about the biopsychosocial needs of TGNC elders to inform case conceptualization and treatment planning to address psychological, social, and medical concerns. Many TGNC elders are socially isolated. Isolation can occur as a result of a loss of social networks through death or through disclosure of a TGNC identity. Psychologists may assist TGNC elders in establishing new social networks that support and value their TGNC identity, while also working to strengthen existing family and friend networks after a TGNC identity has been disclosed. TGNC elders may find special value in relationships with others in their generational cohort or those who may have similar coming-out experiences. Psychologists may encourage TGNC elders to identify ways they can mentor and improve the resilience of younger TGNC generations, creating a sense of generativity (Erikson, 1968) and contribu-

tion while building new supportive relationships. Psychologists working with TGNC elders may help them recognize the sources of their resilience and encourage them to connect with and be active in their communities (Fuhrmann & Craffey, 2014).

For TGNC elders who have chosen not to disclose their gender identity, psychologists may provide support to address shame, guilt, or internalized antitrans prejudice, and validate each person's freedom to choose their pattern of disclosure. Clinicians may also provide validation and empathy when TGNC elders have chosen a model of transition that avoids any disclosure of gender identity and is heavily focused on passing as cisgender.

TGNC elders who choose to undergo a medical or social transition in older adulthood may experience antitrans prejudice from people who question the value of transition at an older age or who believe that these elders are not truly invested in their transition or in a TGNC identity given the length of time they have waited (Auldridge et al., 2012). Some TGNC elders may also grieve lost time and missed opportunities. Psychologists may validate elders' choices to come out, transition, or evolve their gender identity or gender expression at any age, recognizing that such choices may have been much less accessible or viable at earlier stages of TGNC elders' lives.

Psychologists may assist congregating housing, assisted living, or long-term care settings to best meet TGNC elders' needs through respectful communication and affirmation of each person's gender identity and gender expression. Psychologists may work with TGNC people in hospice care systems to develop an end-of-life plan that respects the person's wishes about disclosure of gender identity during and after death.

Assessment, Therapy, and Intervention

Guideline 10. Psychologists strive to understand how mental health concerns may or may not be related to a TGNC person's gender identity and the psychological effects of minority stress.

Rationale. TGNC people may seek assistance from psychologists in addressing gender-related concerns, other mental health issues, or both. Mental health problems experienced by a TGNC person may or may not be related to that person's gender identity and/or may complicate assessment and intervention of gender-related concerns. In some cases, there may not be a relationship between a person's gender identity and a co-occurring condition (e.g., depression, PTSD, substance abuse). In other cases, having a TGNC identity may lead or contribute to a co-occurring mental health condition, either directly by way of gender dysphoria, or indirectly by way of minority stress and oppression (Hendricks & Testa, 2012; I. H. Meyer, 1995, 2003). In extremely rare cases, a co-occurring condition can mimic gender dysphoria (i.e., a psychotic process that distorts the perception of one's gender; Baltieri & De

Andrade, 2009; Hepp, Kraemer, Schnyder, Miller, & Designore, 2004).

Regardless of the presence or absence of an etiological link, gender identity may affect how a TGNC person experiences a co-occurring mental health condition, and/or a co-occurring mental health condition may complicate the person's gender expression or gender identity. For example, an eating disorder may be influenced by a TGNC person's gender expression (e.g., rigid eating patterns used to manage body shape or menstruation may be related to gender identity or gender dysphoria; Ålgars, Alanko, Santtila, & Sandnabba, 2012; Murray, Boon, & Touyz, 2013). In addition, the presence of autism spectrum disorder may complicate a TGNC person's articulation and exploration of gender identity (Jones et al., 2012). In cases in which gender dysphoria is contributing to other mental health concerns, treatment of gender dysphoria may be helpful in alleviating those concerns as well (Keo-Meier et al., 2015).

A relationship also exists between mental health conditions and the psychological sequelae of minority stress that TGNC people can experience. Given that TGNC people experience physical and sexual violence (Clements-Nolle et al., 2006; Kenagy & Bostwick, 2005; Lombardi, Wilchins, Priesing, & Malouf, 2001; Xavier et al., 2005), general harassment and discrimination (Beemyn & Rankin, 2011; Factor & Rothblum, 2007), and employment and housing discrimination (Bradford et al., 2007), they are likely to experience significant levels of minority stress. Studies have demonstrated the disproportionately high levels of negative psychological sequelae related to minority stress, including suicidal ideation and suicide attempts (Center for Substance Abuse Treatment, 2012; Clements-Nolle et al., 2006; Cochran & Cauce, 2006; Nuttbrock et al., 2010; Xavier et al., 2005) and completed suicides (Dhejne et al., 2011; van Kesteren, Asscheman, Megens, & Gooren, 1997). Recent studies have begun to demonstrate an association between sources of external stress and psychological distress (Bockting et al., 2013; Nuttbrock et al., 2010), including suicidal ideation and attempts and self-injurious behavior (Dickey, Reisner, & Juntunen, 2015; Goldblum et al., 2012; Testa et al., 2012).

The minority stress model accounts for both the negative mental health effects of stigma-related stress and the processes by which members of the minority group may develop resilience and resistance to the negative effects of stress (I. H. Meyer, 1995, 2003). Although the minority stress model was developed as a theory of the relationship between sexual orientation and mental disorders, the model has been adapted to TGNC populations (Hendricks & Testa, 2012).

Application. Because of the increased risk of stress-related mental health conditions, psychologists are encouraged to conduct a careful diagnostic assessment, including a differential diagnosis, when working with TGNC people (Coleman et al., 2012). Taking into account the intricate interplay between the effects of mental health symptoms and gender identity and gender expression, psychologists are encouraged to neither ignore mental health problems a TGNC person is experiencing, nor erroneously

assume that those mental health problems are a result of the person's gender identity or gender expression. Psychologists are strongly encouraged to be cautious before determining that gender nonconformity or dysphoria is due to an underlying psychotic process, as this type of causal relationship is rare.

When TGNC people seek to access transition-related health care, a psychosocial assessment is often part of this process (Coleman et al., 2012). A comprehensive and balanced assessment typically includes not only information about a person's past experiences of antitrans prejudice or discrimination, internalized messages related to these experiences, and anticipation of future victimization or rejection (Coolhart, Provancher, Hager, & Wang, 2008), but also coping strategies and sources of resilience (Hendricks & Testa, 2012; Singh et al., 2011). Gathering information about negative life events directly related to a TGNC person's gender identity and gender expression may assist psychologists in understanding the sequelae of stress and discrimination, distinguishing them from concurrent and potentially unrelated mental health problems. Similarly, when a TGNC person has a primary presenting concern that is not gender focused, a comprehensive assessment takes into account that person's experience relative to gender identity and gender expression, including any discrimination, just as it would include assessing other potential trauma history, medical concerns, previous experience with helping professionals, important future goals, and important aspects of identity. Strategies a TGNC person uses to navigate antitrans discrimination could be sources of strength to deal with life challenges or sources of distress that increase challenges and barriers.

Psychologists are encouraged to help TGNC people understand the pervasive influence of minority stress and discrimination that may exist in their lives, potentially including internalized negative attitudes about themselves and their TGNC identity (Hendricks & Testa, 2012). With this support, clients can better understand the origins of their mental health symptoms and normalize their reactions when faced with TGNC-related inequities and discrimination. Minority stress models also identify potentially important sources of resilience. TGNC people can develop resilience when they connect with other TGNC people who provide information on how to navigate antitrans prejudice and increase access to necessary care and resources (Singh et al., 2011). TGNC people may need help developing social support systems to nurture their resilience and bolster their ability to cope with the adverse effects of antitrans prejudice and/or discrimination (Singh & McKleroy, 2011).

Feminizing or masculinizing hormone therapy can positively or negatively affect existing mood disorders (Coleman et al., 2012). Psychologists may also help TGNC people who are in the initial stages of hormone therapy adjust to normal changes in how they experience emotions. For example, trans women who begin estrogens and anti-androgens may experience a broader range of emotions than they are accustomed to, or trans men beginning testosterone might be faced with adjusting to a higher libido

and feeling more emotionally reactive in stressful situations. These changes can be normalized as similar to the emotional adjustments that cisgender women and men experience during puberty. Some TGNC people will be able to adapt existing coping strategies, whereas others may need help developing additional skills (e.g., emotional regulation or assertiveness). Readers are encouraged to refer to the World Professional Association for Transgender Health Standards of Care for discussion of the possible effects of hormone therapy on a TGNC person's mood, affect, and behavior (Coleman et al., 2012).

Guideline 11. Psychologists recognize that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care.

Rationale. Research has primarily shown positive treatment outcomes when TGNC adults and adolescents receive TGNC-affirmative medical and psychological services (i.e., psychotherapy, hormones, surgery; Byne et al., 2012; R. Carroll, 1999; Cohen-Kettenis, Delemarre-van de Waal, & Gooren, 2008; Davis & Meier, 2014; De Cuypere et al., 2006; Gooren, Giltay, & Bunck, 2008; Kuhn et al., 2009), although sample sizes are frequently small with no population-based studies. In a meta-analysis of the hormone therapy treatment literature with TGNC adults and adolescents, researchers reported that 80% of participants receiving trans-affirmative care experienced an improved quality of life, decreased gender dysphoria, and a reduction in negative psychological symptoms (Murad et al., 2010).

In addition, TGNC people who receive social support about their gender identity and gender expression have improved outcomes and quality of life (Brill & Pepper, 2008; Pinto, Melendez, & Spector, 2008). Several studies indicate that family acceptance of TGNC adolescents and adults is associated with decreased rates of negative outcomes, such as depression, suicide, and HIV risk behaviors and infection (Bockting et al., 2013; Dhejne et al., 2011; Grant et al., 2011; Liu & Mustanski, 2012; Ryan, 2009). Family support is also a strong protective factor for TGNC adults and adolescents (Bockting et al., 2013; Moody & Smith, 2013; Ryan et al., 2010). TGNC people, however, frequently experience blatant or subtle antitrans prejudice, discrimination, and even violence within their families (Bradford et al., 2007). Such family rejection is associated with higher rates of HIV infection, suicide, incarceration, and homelessness for TGNC adults and adolescents (Grant et al., 2011; Liu & Mustanski, 2012). Family rejection and lower levels of social support are significantly correlated with depression (Clements-Nolle et al., 2006; Ryan, 2009). Many TGNC people seek support through peer relationships, chosen families, and communities in which they may be more likely to experience acceptance (Gonzalez & McNulty, 2010; Nuttbrock et al., 2009). Peer support from other TGNC people has been found to be a moderator between antitrans discrimination and mental health, with higher levels of peer support associated with better mental health (Bockting et al., 2013). For some TGNC people, support from religious and spiritual communities provides

an important source of resilience (Glaser, 2008; Kidd & Witten, 2008; Porter et al., 2013).

Application. Given the strong evidence for the positive influence of affirmative care, psychologists are encouraged to facilitate access to and provide trans-affirmative care to TGNC people. Whether through the provision of assessment and psychotherapy, or through assisting clients to access hormone therapy or surgery, psychologists may play a critical role in empowering and validating TGNC adults' and adolescents' experiences and increasing TGNC people's positive life outcomes (Bess & Stabb, 2009; Rachlin, 2002).

Psychologists are also encouraged to be aware of the importance of affirmative social support and assist TGNC adults and adolescents in building social support networks in which their gender identity is accepted and affirmed. Psychologists may assist TGNC people in negotiating family dynamics that may arise in the course of exploring and establishing gender identity. Depending on the context of psychological practice, these issues might be addressed in individual work with TGNC clients, conjoint sessions including members of their support system, family therapy, or group therapy. Psychologists may help TGNC people decide how and when to reveal their gender identity at work or school, in religious communities, and to friends and contacts in other settings. TGNC people who decide not to come out in all aspects of their lives can still benefit from TGNC-affirmative in-person or online peer support groups.

Clients may ask psychologists to assist family members in exploring feelings about their loved one's gender identity and gender expression. Published models of family adjustment (Emerson & Rosenfeld, 1996) may be useful to help normalize family members' reactions upon learning that they have a TGNC family member, and to reduce feelings of isolation. When working with family members or significant others, it may be helpful to normalize feelings of loss or fear of what may happen to current relationships as TGNC people disclose their gender identity and expression to others. Psychologists may help significant others adjust to changing relationships and consider how to talk to extended family, friends, and other community members about TGNC loved ones. Providing significant others with referrals to TGNC-affirmative providers, educational resources, and support groups can have a profound impact on their understanding of gender identity and their communication with TGNC loved ones. Psychologists working with couples and families may also help TGNC people identify ways to include significant others in their social or medical transition.

Psychologists working with TGNC people in rural settings may provide clients with resources to connect with other TGNC people online or provide information about in-person support groups in which they can explore the unique challenges of being TGNC in these geographic areas (Walinsky & Whitcomb, 2010). Psychologists serving TGNC military and veteran populations are encouraged to be sensitive to the barriers these individuals face, especially for people who are on active duty in the U.S. military

(OutServe-Servicemembers Legal Defense Network, n.d.). Psychologists may help TGNC military members and veterans establish specific systems of support that create a safe and affirming space to reduce isolation and to create a network of peers with a shared military experience. Psychologists who work with veterans are encouraged to educate themselves on recent changes to VA policy that support equal access to VA medical and mental health services (Department of Veterans Affairs, Veterans' Health Administration, 2013).

Guideline 12. Psychologists strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people.

Rationale. Relationships involving TGNC people can be healthy and successful (Kins, Hoebeke, Heylens, Rubens, & De Cuypere, 2008; Meier, Sharp, Michonski, Babcock, & Fitzgerald, 2013) as well as challenging (Brown, 2007; Iantaffi & Bockting, 2011). A study of successful relationships between TGNC men and cisgender women found that these couples attributed the success of their relationship to respect, honesty, trust, love, understanding, and open communication (Kins et al., 2008). Just as relationships between cisgender people can involve abuse, so can relationships between TGNC people and their partners (Brown, 2007), with some violent partners threatening to disclose a TGNC person's identity to exact control in the relationship (FORGE, n.d.).

In the early decades of medical and social transition for TGNC people, only those whose sexual orientations would be heterosexual posttransition (e.g., trans woman with a cisgender man) were deemed eligible for medical and social transition (Meyerowitz, 2002). This restriction prescribed only certain relationship partners (American Psychiatric Association, 1980; Benjamin, 1966; Chivers & Bailey, 2000), denied access to surgery for trans men identifying as gay or bisexual (Coleman & Bockting, 1988), or trans women identifying as lesbian or bisexual, and even required that TGNC people's existing legal marriages be dissolved before they could gain access to transition care (Lev, 2004).

Disclosure of a TGNC identity can have an important impact on the relationship between TGNC people and their partners. Disclosure of TGNC status earlier in the relationship tends to be associated with better relationship outcomes, whereas disclosure of TGNC status many years into an existing relationship may be perceived as a betrayal (Erhardt, 2007). When a TGNC person comes out in the context of an existing relationship, it can also be helpful if both partners are involved in decision making about the use of shared resources (i.e., how to balance the financial costs of transition with other family needs) and how to share this news with shared supports (i.e., friends and family). Sometimes relationship roles are renegotiated in the context of a TGNC person coming out to their partner (Samons, 2008). Assumptions about what it means to be a "husband" or a "wife" can shift if the gender identity of one's spouse shifts

(Erhardt, 2007). Depending on when gender issues are disclosed and how much of a change this creates in the relationship, partners may grieve the loss of aspects of their partner and the way the relationship used to be (Lev, 2004).

Although increasing alignment between gender identity and gender expression, whether it be through dress, behavior, or through medical interventions (i.e., hormones, surgery), does not necessarily affect to whom a TGNC person is attracted (Coleman et al., 1993), TGNC people may become more open to exploring their sexual orientation, may redefine sexual orientation as they move through transition, or both (Daskalos, 1998; H. Devor, 1993; Schleifer, 2006). Through increased comfort with their body and gender identity, TGNC people may explore aspects of their sexual orientation that were previously hidden or that felt discordant with their sex assigned at birth. Following a medical and/or social transition, a TGNC person's sexual orientation may remain constant or shift, either temporarily or permanently (e.g., renewed exploration of sexual orientation in the context of TGNC identity, shift in attraction or choice of sexual partners, widened spectrum of attraction, shift in sexual orientation identity; Meier, Sharp et al., 2013; Samons, 2008). For example, a trans man previously identified as a lesbian may later be attracted to men (Coleman et al., 1993; dickey, Burnes, & Singh, 2012), and a trans woman attracted to women pretransition may remain attracted to women posttransition (Lev, 2004).

Some TGNC people and their partners may fear the loss of mutual sexual attraction and other potential effects of shifting gender identities in the relationship. Lesbian-identified partners of trans men may struggle with the idea that being in a relationship with a man may cause others to perceive them as a heterosexual couple (Califia, 1997). Similarly, women in heterosexual relationships who later learn that their partners are trans women may be unfamiliar with navigating stigma associated with sexual minority status when viewed as a lesbian couple (Erhardt, 2007). Additionally, partners may find they are not attracted to a partner after transition. As an example, a lesbian whose partner transitions to a male identity may find that she is no longer attracted to this person because she is not sexually attracted to men. Partners of TGNC people may also experience grief and loss as their partners engage in social and/or medical transitions.

Application. Psychologists may help foster resilience in relationships by addressing issues specific to partners of TGNC people. Psychologists may provide support to partners of TGNC people who are having difficulty with their partner's evolving gender identity or transition, or are experiencing others having difficulty with the partner's transition. Partner peer support groups may be especially helpful in navigating internalized antitrans prejudice, shame, resentment, and relationship concerns related to a partner's gender transition. Meeting or knowing other TGNC people, other partners of TGNC people, and couples who have successfully navigated transition may also help TGNC people and their partners and serve as a protective factor (Brown, 2007). When TGNC status is disclosed during an existing relationship, psychologists may help

couples explore which relationship dynamics they want to preserve and which they might like to change.

In working with psychologists, TGNC people may explore a range of issues in their relationships and sexuality (dickey et al., 2012), including when and how to come out to current or potential romantic and sexual partners, communicating their sexual desires, renegotiating intimacy that may be lost during the TGNC partner's transition, adapting to bodily changes caused by hormone use or surgery, and exploring boundaries regarding touch, affection, and safer sex practices (Iantaffi & Bockting, 2011; Sevelius, 2009). TGNC people may experience increased sexual self-efficacy through transition. Although psychologists may aid partners in understanding a TGNC person's transition decisions, TGNC people may also benefit from help in cultivating awareness of the ways in which these decisions influence the lives of loved ones.

Guideline 13. Psychologists seek to understand how parenting and family formation among TGNC people take a variety of forms.

Rationale. Psychologists work with TGNC people across the life span to address parenting and family issues (Kenagy & Hsieh, 2005). There is evidence that many TGNC people have and want children (Wierckx et al., 2012). Some TGNC people conceive a child through sexual intercourse, whereas others may foster, adopt, pursue surrogacy, or employ assisted reproductive technologies, such as sperm or egg donation, to build or expand a family (De Sutter, Kira, Verschoor, & Hotimsky, 2002). Based on a small body of research to date, there is no indication that children of TGNC parents suffer long-term negative impacts directly related to parental gender change (R. Green, 1978, 1988; White & Ettner, 2004). TGNC people may find it both challenging to find medical providers who are willing to offer them reproductive treatment and to afford the cost (Coleman et al., 2012). Similarly, adoption can be quite costly, and some TGNC people may find it challenging to find foster care or adoption agencies that will work with them in a nondiscriminatory manner. Current or past use of hormone therapy may limit fertility and restrict a TGNC person's reproductive options (Darnery, 2008; Wierckx et al., 2012). Other TGNC people may have children or families before coming out as TGNC or beginning a gender transition.

TGNC people may present with a range of parenting and family-building concerns. Some will seek support to address issues within preexisting family systems, some will explore the creation or expansion of a family, and some will need to make decisions regarding potential fertility issues related to hormone therapy, pubertal suppression, or surgical transition. The medical and/or social transition of a TGNC parent may shift family dynamics, creating challenges and opportunities for partners, children, and other family members. One study of therapists' reflections on their experiences with TGNC clients suggested that family constellation and the parental relationship was more significant for children than the parent's social and/or medical

transition itself (White & Ettner, 2004). Although research has not documented that the transitions of TGNC people have an effect on their parenting abilities, preexisting partnerships or marriages may not survive the disclosure of a TGNC identity or a subsequent transition (dickey et al., 2012). This may result in divorce or separation, which may affect the children in the family. A positive relationship between parents, regardless of marital status, has been suggested to be an important protective factor for children (Amato, 2001; White & Ettner, 2007). This seems to be the case especially when children are reminded of the parent's love and assured of the parent's continued presence in their life (White & Ettner, 2007). Based on a small body of literature available, it is generally the case that younger children are best able to incorporate the transition of a parent, followed by adult children, with adolescents generally having the most difficulty (White & Ettner, 2007). If separated or divorced from their partners or spouses, TGNC parents may be at risk for loss of custody or visitation rights because some courts presume that there is a nexus between their gender identity or gender expression and parental fitness (Flynn, 2006). This type of prejudice is especially common for TGNC people of color (Grant et al., 2011).

Application. Psychologists are encouraged to attend to the parenting and family-building concerns of TGNC people. When working with TGNC people who have previous parenting experience, psychologists may help TGNC people identify how being a parent may influence decisions to come out as TGNC or to begin a transition (Freeman, Tasker, & Di Ceglie, 2002; Grant et al., 2011; Wierckx et al., 2012). Some TGNC people may choose to delay disclosure until their children have grown and left home (Bethua & McCollum, 2013). Clinical guidelines jointly developed by a Vancouver, British Columbia, TGNC community organization and a health care provider organization encourage psychologists and other mental health providers working with TGNC people to plan for disclosure to a partner, previous partner, or children, and to pay particular attention to resources that assist TGNC people to discuss their identity with children of various ages in developmentally appropriate ways (Bockting et al., 2006). Lev (2004) uses a developmental stage framework for the process that family members are likely to go through in coming to terms with a TGNC family member's identity that some psychologists may find helpful. Awareness of peer support networks for spouses and children of TGNC people can also be helpful (e.g., PFLAG, TransYouth Family Allies). Psychologists may provide family counseling to assist a family in managing disclosure, improve family functioning, and maintain family involvement of the TGNC person, as well as aiding the TGNC person in attending to the ways that their transition process has affected their family members (Samons, 2008). Helping parents to continue to work together to focus on the needs of their children and to maintain family bonds is likely to lead to the best results for the children (White & Ettner, 2007).

For TGNC people with existing families, psychologists may support TGNC people in seeking legal counsel regarding parental rights in adoption or custody. Depending on the situation, this may be desirable even if the TGNC parent is biologically related to the child (Minter & Wald, 2012). Although being TGNC is not a legal impediment to adoption in the United States, there is the potential for overt and covert discrimination and barriers, given the widespread prejudice against TGNC people. The question of whether to disclose TGNC status on an adoption application is a personal one, and a prospective TGNC parent would benefit from consulting a lawyer for legal advice, including what the laws in their jurisdiction say about disclosure. Given the extensive background investigation frequently conducted, it may be difficult to avoid disclosure. Many lawyers favor disclosure to avoid any potential legal challenges during the adoption process (Minter & Wald, 2012).

In discussing family-building options with TGNC people, psychologists are encouraged to remain aware that some of these options require medical intervention and are not available everywhere, in addition to being quite costly (Coleman et al., 2012). Psychologists may work with clients to manage feelings of loss, grief, anger, and resentment that may arise if TGNC people are unable to access or afford the services they need for building a family (Bockting et al., 2006; De Sutter et al., 2002).

When TGNC people consider beginning hormone therapy, psychologists may engage them in a conversation about the possibly permanent effects on fertility to better prepare TGNC people to make a fully informed decision. This may be of special importance with TGNC adolescents and young adults who often feel that family planning or loss of fertility is not a significant concern in their current daily lives, and therefore disregard the long-term reproductive implications of hormone therapy or surgery (Coleman et al., 2012). Psychologists are encouraged to discuss contraception and safer sex practices with TGNC people, given that they may still have the ability to conceive even when undergoing hormone therapy (Bockting, Robinson, & Rosser, 1998). Psychologists may play a critical role in educating TGNC adolescents and young adults and their parents about the long-term effects of medical interventions on fertility and assist them in offering informed consent prior to pursuing such interventions. Although hormone therapy may limit fertility (Coleman et al., 2012), psychologists may encourage TGNC people to refrain from relying on hormone therapy as the sole means of birth control, even when a person has amenorrhea (Gorton & Grubb, 2014). Education on safer sex practices may also be important, as some segments of the TGNC community (e.g., trans women and people of color) are especially vulnerable to sexually transmitted infections and have been shown to have high prevalence and incidence rates of HIV infection (Kellogg, Clements-Nolle, Dilley, Katz, & McFarland, 2001; Nemoto, Operario, Keatley, Han, & Soma, 2004).

Depending on the timing and type of options selected, psychologists may explore the physical, social, and emotional implications should TGNC people choose to delay or

stop hormone therapy, undergo fertility treatment, or become pregnant. Psychological effects of stopping hormone therapy may include depression, mood swings, and reactions to the loss of physical masculinization or feminization facilitated by hormone therapy (Coleman et al., 2012). TGNC people who choose to halt hormone therapy during attempts to conceive or during a pregnancy may need additional psychological support. For example, TGNC people and their families may need help in managing the additional antitrans prejudice and scrutiny that may result when a TGNC person with stereotypically masculine features becomes visibly pregnant. Psychologists may also assist TGNC people in addressing their loss when they cannot engage in reproductive activities that are consistent with their gender identity, or when they encounter barriers to conceiving, adopting, or fostering children not typically faced by other people (Vanderburgh, 2007). Psychologists are encouraged to assess the degree to which reproductive health services are TGNC-affirmative prior to referring TGNC people to them. Psychologists are also encouraged to provide TGNC-affirmative information to reproductive health service personnel when there is a lack of trans-affirmative knowledge.

Guideline 14. Psychologists recognize the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers.

Rationale. Collaboration across disciplines can be crucial when working with TGNC people because of the potential interplay of biological, psychological, and social factors in diagnosis and treatment (Hendricks & Testa, 2012). The challenges of living with a stigmatized identity and the need of many TGNC people to transition, socially and/or medically, may call for the involvement of health professionals from various disciplines, including psychologists, psychiatrists, social workers, primary health care providers, endocrinologists, nurses, pharmacists, surgeons, gynecologists, urologists, electrologists, speech therapists, physical therapists, pastoral counselors and chaplains, and career or educational counselors. Communication, cooperation, and collaboration will ensure optimal coordination and quality of care. Just as psychologists often refer TGNC people to medical providers for assessment and treatment of medical issues, medical providers may rely on psychologists to assess readiness and assist TGNC clients to prepare for the psychological and social aspects of transition before, during, and after medical interventions (Coleman et al., 2012; Hembree et al., 2009; Lev, 2009). Outcome research to date supports the value and effectiveness of an interdisciplinary, collaborative approach to TGNC-specific care (see Coleman et al., 2012 for a review).

Application. Psychologists' collaboration with colleagues in medical and associated health disciplines involved in TGNC clients' care (e.g., hormonal and surgical treatment, primary health care; Coleman et al., 2012; Lev, 2009) may take many forms and should occur in a timely manner that does not complicate access to needed

services (e.g., considerations of wait time). For example, a psychologist working with a trans man who has a diagnosis of bipolar disorder may need to coordinate with his primary care provider and psychiatrist to adjust his hormone levels and psychiatric medications, given that testosterone can have an activating effect, in addition to treating gender dysphoria. At a basic level, collaboration may entail the creation of required documentation that TGNC people present to surgeons or medical providers to access gender-affirming medical interventions (e.g., surgery, hormone therapy; Coleman et al., 2012). Psychologists may offer support, information, and education to interdisciplinary colleagues who are unfamiliar with issues of gender identity and gender expression to assist TGNC people in obtaining TGNC-affirmative care (Holman & Goldberg, 2006; Lev, 2009). For example, a psychologist who is assisting a trans woman with obtaining gender-affirming surgery may, with her consent, contact her new gynecologist in preparation for her first medical visit. This contact could include sharing general information about her gender history and discussing how both providers could most affirmatively support appropriate health checks to ensure her best physical health (Holman & Goldberg, 2006).

Psychologists in interdisciplinary settings could also collaborate with medical professionals prescribing hormone therapy by educating TGNC people and ensuring TGNC people are able to make fully informed decisions prior to starting hormone treatment (Coleman et al., 2012; Deutsch, 2012; Lev, 2009). Psychologists working with children and adolescents play a particularly important role on the interdisciplinary team due to considerations of cognitive and social development, family dynamics, and degree of parental support. This role is especially crucial when providing psychological evaluation to determine the appropriateness and timeliness of a medical intervention. When psychologists are not part of an interdisciplinary setting, especially in isolated or rural communities, they can identify interdisciplinary colleagues with whom they may collaborate and/or refer (Walinsky & Whitcomb, 2010). For example, a rural psychologist could identify a trans-affirmative pediatrician in a surrounding area and collaborate with the pediatrician to work with parents raising concerns about their TGNC and questioning children and adolescents.

In addition to working collaboratively with other providers, psychologists who obtain additional training to specialize in work with TGNC people may also serve as consultants in the field (e.g., providing additional support to providers working with TGNC people or assisting school and workplaces with diversity training). Psychologists who have expertise in working with TGNC people may play a consultative role with providers in inpatient settings seeking to provide affirmative care to TGNC clients. Psychologists may also collaborate with social service colleagues to provide TGNC people with affirmative referrals related to housing, financial support, vocational/educational counseling and training, TGNC-affirming religious or spiritual communities, peer support, and other community resources (Gehi & Arkles, 2007). This collaboration might also in-

clude assuring that TGNC people who are minors in the care of the state have access to culturally appropriate care.

Research, Education, and Training

Guideline 15. Psychologists respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.

Rationale. Historically, in a set of demographic questions, psychological research has included one item on either sex or gender, with two response options—male and female. This approach wastes an opportunity to increase knowledge about TGNC people for whom neither option may fit their identity, and runs the risk of alienating TGNC research participants (IOM, 2011). For example, there is little knowledge about HIV prevalence, risks, and prevention needs of TGNC people because most of the research on HIV has not included demographic questions to identify TGNC participants within their samples. Instead, TGNC people have been historically subsumed within larger demographic categories (e.g., men who have sex with men, women of color), rendering the impact of the HIV epidemic on the TGNC population invisible (Herbst et al., 2008). Scholars have noted that this invisibility fails to draw attention to the needs of TGNC populations that experience the greatest health disparities, including TGNC people who are of color, immigrants, low income, homeless, veterans, incarcerated, live in rural areas, or have disabilities (Bauer et al., 2009; Hanssmann, Morrison, Russian, Shiu-Thornton, & Bowen, 2010; Shipherd et al., 2012; Walinsky & Whitcomb, 2010).

There is a great need for more research to inform practice, including affirmative treatment approaches with TGNC people. Although sufficient evidence exists to support current standards of care (Byne et al., 2012; Coleman et al., 2012), much is yet to be learned to optimize quality of care and outcome for TGNC clients, especially as it relates to the treatment of children (IOM, 2011; Mikalson et al., 2012). In addition, some research with TGNC populations has been misused and misinterpreted, negatively affecting TGNC people's access to health services to address issues of gender identity and gender expression (Namaste, 2000). This has resulted in justifiable skepticism and suspicion in the TGNC community when invited to participate in research initiatives. In accordance with the APA ethics code (APA, 2010), psychologists conduct research and distribute research findings with integrity and respect for their research participants. As TGNC research increases, some TGNC communities may experience being oversampled in particular geographic areas and/or TGNC people of color may not be well-represented in TGNC studies (Hwahng & Lin, 2009; Namaste, 2000).

Application. All psychologists conducting research, even when not specific to TGNC populations, are encouraged to provide a range of options for capturing demographic information about TGNC people so that TGNC people may be included and accurately represented

(Conron et al., 2008; Deutsch et al., 2013). One group of experts has recommended that population research, and especially government-sponsored surveillance research, use a two-step method, first asking for sex assigned at birth, and then following with a question about gender identity (GenIUSS, 2013). For research focused on TGNC people, including questions that assess both sex assigned at birth and current gender identity allows the disaggregation of subgroups within the TGNC population and has the potential to increase knowledge of differences within the population. In addition, findings about one subgroup of TGNC people may not apply to other subgroups. For example, results from a study of trans women of color with a history of sex work who live in urban areas (Nemoto, Operario, Keatley, & Villegas, 2004) may not generalize to all TGNC women of color or to the larger TGNC population (Bauer, Travers, Scanlon, & Coleman, 2012; Operario et al., 2008).

In conducting research with TGNC people, psychologists will confront the challenges associated with studying a relatively small, geographically dispersed, diverse, stigmatized, hidden, and hard-to-reach population (IOM, 2011). Because TGNC individuals are often hard to reach (IOM, 2011) and TGNC research is rapidly evolving, it is important to consider the strengths and limitations of the methods that have been or may be used to study the TGNC population, and to interpret and represent findings accordingly. Some researchers have strongly recommended collaborative research models (e.g., participatory action research) in which TGNC community members are integrally involved in these research activities (Clements-Nolle & Bachrach, 2003; Singh, Richmond, & Burnes, 2013). Psychologists who seek to educate the public by communicating research findings in the popular media will also confront challenges, because most journalists have limited knowledge about the scientific method and there is potential for the media to misinterpret, exploit, or sensationalize findings (Garber, 1992; Namaste, 2000).

Guideline 16. Psychologists Seek to Prepare Trainees in Psychology to Work Competently With TGNC People.

Rationale. The *Ethical Principles of Psychologists and Code of Conduct* (APA, 2010) include gender identity as one factor for which psychologists may need to obtain training, experience, consultation, or supervision in order to ensure their competence (APA, 2010). In addition, when APA-accredited programs are required to demonstrate a commitment to cultural and individual diversity, gender identity is specifically included (APA, 2015). Yet surveys of TGNC people suggest that many mental health care providers lack even basic knowledge and skills required to offer trans-affirmative care (Bradford et al., 2007; O'Hara, Dispenza, Brack, & Blood, 2013; Xavier et al., 2005). The APA Task Force on Gender Identity and Gender Variance (2009) projected that many, if not most, psychologists and graduate psychology students will at some point encounter TGNC people among their clients, colleagues, and trainees. Yet professional education and training in psychology includes little or no preparation for

working with TGNC people (Anton, 2009; APA TFGIGV, 2009), and continuing professional education available to practicing mental health clinicians is also scant (Lurie, 2005). Only 52% percent of psychologists and graduate students who responded to a survey conducted by an APA Task Force reported having had the opportunity to learn about TGNC issues in school; of those respondents, only 27% reported feeling adequately familiar with gender concerns ($n = 294$; APA TFGIGV, 2009).

Training on gender identity in professional psychology has frequently been subsumed under discussions of sexual orientation or in classes on human sexuality. Some scholars have suggested that psychologists and students may mistakenly believe that they have obtained adequate knowledge and awareness about TGNC people through training focused on LGB populations (Harper & Schneider, 2003). However, Israel and colleagues have found important differences between the therapeutic needs of TGNC people and those of LGB people in the perceptions of both clients and providers (Israel et al., 2008; Israel, Walther, Gorcheva, & Perry, 2011). Nadal and colleagues have suggested that the absence of distinct, accurate information about TGNC populations in psychology training not only perpetuates misunderstanding and marginalization of TGNC people by psychologists but also contributes to continued marginalization of TGNC people in society as a whole (Nadal et al., 2010, 2012).

Application. Psychologists strive to continue their education on issues of gender identity and gender expression with TGNC people as a foundational component of affirmative psychological practice. In addition to these guidelines, which educators may use as a resource in developing curricula and training experiences, ACA (2010) has also adopted a set of competencies that may be a helpful resource for educators. In addition to including TGNC people and their issues in foundational education in health service psychology (e.g., personality development, multiculturalism, research methods), some psychology programs may also provide coursework and training for students interested in developing more advanced expertise on issues of gender identity and gender expression.

Because of the high level of societal ignorance and stigma associated with TGNC people, ensuring that psychological education, training, and supervision is affirmative, and does not sensationalize (Namaste, 2000), exploit, or pathologize TGNC people (Lev, 2004), will require care on the part of educators. Students will benefit from support from their educators in developing a professional, nonjudgmental attitude toward people who may have a different experience of gender identity and gender expression from their own. A number of training resources have been published that may be helpful to psychologists in integrating information about TGNC people into the training they offer (e.g., Catalano, McCarthy, & Shlasko, 2007; Stryker, 2008; Wentling, Schilt, Windsor, & Lucal, 2008). Because most psychologists have had little or no training on TGNC populations and do not perceive themselves as having sufficient understanding of issues related to gender identity and gender expression (APA TFGIGV, 2009), psycholo-

gists with relevant expertise are encouraged to develop and distribute continuing education and training to help to address these gaps. Psychologists providing education can incorporate activities that increase awareness of cisgender privilege, antitrans prejudice and discrimination, host a panel of TGNC people to offer personal perspectives, or include narratives of TGNC people in course readings (ACA, 2010). When engaging these approaches, it is important to include a wide variety of TGNC experiences to reflect the inherent diversity within the TGNC community.

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Appendix A Definitions

Terminology within the health care field and transgender and gender nonconforming (TGNC) communities is constantly evolving (Coleman et al., 2012). The evolution of terminology has been especially rapid in the last decade, as the profession's awareness of gender diversity has increased, as more literature and research in this area has been published, and as voices of the TGNC community have strengthened. Some terms or definitions are not universally accepted, and there is some disagreement among professionals and communities as to the “correct” words or definitions, depending on theoretical orientation, geographic region, generation, or culture, with some terms seen as affirming and others as outdated or demeaning. American Psychological Association (APA) Task Force for *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* developed the definitions below by reviewing existing

definitions put forward by professional organizations (e.g., APA Task Force on Gender Identity and Gender Variance, 2009; the Institute of Medicine, 2011; and the World Professional Association for Transgender Health [Coleman et al., 2012]), health care agencies serving TGNC clients (e.g., Fenway Health Center), TGNC community resources (Gender Equity Resource Center, National Center for Transgender Equality), and professional literature. Psychologists are encouraged to refresh their knowledge and familiarity with evolving terminology on a regular basis as changes emerge in the community and/or the professional literature. The definitions below include terms frequently used within the *Guidelines*, by the TGNC community, and within professional literature.

Ally: a cisgender person who supports and advocates for TGNC people and/or communities.

(Appendices continue)

Antitrans prejudice (transprejudice, transnegativity, transphobia): prejudicial attitudes that may result in the devaluing, dislike, and hatred of people whose gender identity and/or gender expression do not conform to their sex assigned at birth. Antitrans prejudice may lead to discriminatory behaviors in such areas as employment and public accommodations, and may lead to harassment and violence. When TGNC people hold these negative attitudes about themselves and their gender identity, it is called *internalized transphobia* (a construct analogous to internalized homophobia). Transmisogyny describes a simultaneous experience of sexism and antitrans prejudice with particularly adverse effects on trans women.

Cisgender: an adjective used to describe a person whose gender identity and gender expression align with sex assigned at birth; a person who is not TGNC.

Cisgenderism: a systemic bias based on the ideology that gender expression and gender identities are determined by sex assigned at birth rather than self-identified gender identity. Cisgenderism may lead to prejudicial attitudes and discriminatory behaviors toward TGNC people or to forms of behavior or gender expression that lie outside of the traditional gender binary.

Coming out: a process by which individuals affirm and actualize a stigmatized identity. Coming out as TGNC can include disclosing a gender identity or gender history that does not align with sex assigned at birth or current gender expression. Coming out is an individual process and is partially influenced by one's age and other generational influences.

Cross dressing: wearing clothing, accessories, and/or make-up, and/or adopting a gender expression not associated with a person's assigned sex at birth according to cultural and environmental standards (Bullough & Bullough, 1993). Cross-dressing is not always reflective of gender identity or sexual orientation. People who cross-dress may or may not identify with the larger TGNC community.

Disorders of sex development (DSD, Intersex): term used to describe a variety of medical conditions associated with atypical development of an individual's physical sex characteristics (Hughes, Houk, Ahmed, & Lee, 2006). These conditions may involve differences of a person's internal and/or external reproductive organs, sex chromosomes, and/or sex-related hormones that may complicate sex assignment at birth. DSD conditions may be considered variations in biological diversity rather than disorders (M. Diamond, 2009); therefore some prefer the terms *intersex*, *intersexuality*, or *differences in sex development* rather than "disorders of sex development" (Coleman et al., 2012).

Drag: the act of adopting a gender expression, often as part of a performance. Drag may be enacted as a political

comment on gender, as parody, or as entertainment, and is not necessarily reflective of gender identity.

Female-to-male (FTM): individuals assigned a female sex at birth who have changed, are changing, or wish to change their body and/or gender identity to a more masculine body or gender identity. FTM persons are also often referred to as *transgender men*, *transmen*, or *trans men*.

Gatekeeping: the role of psychologists and other mental health professionals of evaluating a TGNC person's eligibility and readiness for hormone therapy or surgery according to the Standards of Care set forth by the World Professional Association for Transgender Health (Coleman et al., 2012). In the past, this role has been perceived as limiting a TGNC adult's autonomy and contributing to mistrust between psychologists and TGNC clients. Current approaches are sensitive to this history and are more affirming of a TGNC adult's autonomy in making decisions with regard to medical transition (American Counseling Association, 2010; Coleman et al., 2012; Singh & Burnes, 2010).

Gender-affirming surgery (sex reassignment surgery or gender reassignment surgery): surgery to change primary and/or secondary sex characteristics to better align a person's physical appearance with their gender identity. Gender-affirming surgery can be an important part of medically necessary treatment to alleviate gender dysphoria and may include mastectomy, hysterectomy, metoidioplasty, phalloplasty, breast augmentation, orchiectomy, vaginoplasty, facial feminization surgery, and/or other surgical procedures.

Gender binary: the classification of gender into two discrete categories of boy/man and girl/woman.

Gender dysphoria: discomfort or distress related to incongruence between a person's gender identity, sex assigned at birth, gender identity, and/or primary and secondary sex characteristics (Knudson, De Cuypere, & Bockting, 2010). In 2013, the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*; American Psychiatric Association, 2013) adopted the term *gender dysphoria* as a diagnosis characterized by "a marked incongruence between" a person's gender assigned at birth and gender identity (American Psychiatric Association, 2013, p. 453). Gender dysphoria replaced the diagnosis of gender identity disorder (GID) in the previous version of the *DSM* (American Psychiatric Association, 2000).

Gender expression: the presentation of an individual, including physical appearance, clothing choice and accessories, and behaviors that express aspects of gender identity or role. Gender expression may or may not conform to a person's gender identity.

(Appendices continue)

Gender identity: a person's deeply felt, inherent sense of being a boy, a man, or male; a girl, a woman, or female; or an alternative gender (e.g., genderqueer, gender nonconforming, gender neutral) that may or may not correspond to a person's sex assigned at birth or to a person's primary or secondary sex characteristics. Because gender identity is internal, a person's gender identity is not necessarily visible to others. "Affirmed gender identity" refers to a person's gender identity after coming out as TGNC or undergoing a social and/or medical transition process.

Gender marker: an indicator (M, F) of a person's sex or gender found on identification (e.g., driver's license, passport) and other legal documents (e.g., birth certificate, academic transcripts).

Gender nonconforming (GNC): an adjective used as an umbrella term to describe people whose gender expression or gender identity differs from gender norms associated with their assigned birth sex. Subpopulations of the TGNC community can develop specialized language to represent their experience and culture, such as the term "masculine of center" (MOC; [Cole & Han, 2011](#)) that is used in communities of color to describe one's GNC identity.

Gender questioning: an adjective to describe people who may be questioning or exploring their gender identity and whose gender identity may not align with their sex assigned at birth.

Genderqueer: a term to describe a person whose gender identity does not align with a binary understanding of gender (i.e., a person who does not identify fully as either a man or a woman). People who identify as genderqueer may redefine gender or decline to define themselves as gendered altogether. For example, people who identify as genderqueer may think of themselves as both man and woman (bigender, pangender, androgyne); neither man nor woman (genderless, gender neutral, neutrois, agender); moving between genders (genderfluid); or embodying a third gender.

Gender role: refers to a pattern of appearance, personality, and behavior that, in a given culture, is associated with being a boy/man/male or being a girl/woman/female. The appearance, personality, and behavior characteristics may or may not conform to what is expected based on a person's sex assigned at birth according to cultural and environmental standards. Gender role may also refer to the *social* role in which one is living (e.g., as a woman, a man, or another gender), with some role characteristics conforming and others not conforming to what is associated with girls/women or boys/men in a given culture and time.

Hormone therapy (gender-affirming hormone therapy, hormone replacement therapy): the use of hormones to masculinize or feminize a person's body to better

align that person's physical characteristics with their gender identity. People wishing to feminize their body receive antiandrogens and/or estrogens; people wishing to masculinize their body receive testosterone. Hormone therapy may be an important part of medically necessary treatment to alleviate gender dysphoria.

Male-to-female (MTF): individuals whose assigned sex at birth was male and who have changed, are changing, or wish to change their body and/or gender role to a more feminized body or gender role. MTF persons are also often referred to as *transgender women*, *transwomen*, or *trans women*.

Passing: the ability to blend in with cisgender people without being recognized as transgender based on appearance or gender role and expression; being perceived as cisgender. Passing may or may not be a goal for all TGNC people.

Puberty suppression (puberty blocking, puberty delaying therapy): a treatment that can be used to temporarily suppress the development of secondary sex characteristics that occur during puberty in youth, typically using gonadotropin-releasing hormone (GnRH) analogues. Puberty suppression may be an important part of medically necessary treatment to alleviate gender dysphoria. Puberty suppression can provide adolescents time to determine whether they desire less reversible medical intervention and can serve as a diagnostic tool to determine if further medical intervention is warranted.

Sex (sex assigned at birth): sex is typically assigned at birth (or before during ultrasound) based on the appearance of external genitalia. When the external genitalia are ambiguous, other indicators (e.g., internal genitalia, chromosomal and hormonal sex) are considered to assign a sex, with the aim of assigning a sex that is most likely to be congruent with the child's gender identity ([MacLaughlin & Donahoe, 2004](#)). For most people, gender identity is congruent with sex assigned at birth (see *cisgender*); for TGNC individuals, gender identity differs in varying degrees from sex assigned at birth.

Sexual orientation: a component of identity that includes a person's sexual and emotional attraction to another person and the behavior and/or social affiliation that may result from this attraction. A person may be attracted to men, women, both, neither, or to people who are genderqueer, androgynous, or have other gender identities. Individuals may identify as lesbian, gay, heterosexual, bisexual, queer, pansexual, or asexual, among others.

Stealth (going stealth): a phrase used by some TGNC people across the life span (e.g., children, adolescents) who choose to make a transition in a new environment (e.g., school) in their affirmed gender without openly sharing their identity as a TGNC person.

(Appendices continue)

TGNC: an abbreviation used to refer to people who are transgender or gender nonconforming.

Trans: common short-hand for the terms transgender, transsexual, and/or gender nonconforming. Although the term “trans” is commonly accepted, not all transsexual or gender nonconforming people identify as trans.

Trans-affirmative: being respectful, aware and supportive of the needs of TGNC people.

Transgender: an adjective that is an umbrella term used to describe the full range of people whose gender identity and/or gender role do not conform to what is typically associated with their sex assigned at birth. Although the term “transgender” is commonly accepted, not all TGNC people self-identify as transgender.

Transgender man, trans man, or transman: a person whose sex assigned at birth was female, but who identifies as a man (see FTM).

Transgender woman, trans woman, or transwoman: a person whose sex assigned at birth was male, but who identifies as a woman (see MTF).

Transition: a process some TGNC people progress through when they shift toward a gender role that differs from the one associated with their sex assigned at birth. The length, scope, and process of transition are unique to

each person’s life situation. For many people, this involves developing a gender role and expression that is more aligned with their gender identity. A transition typically occurs over a period of time; TGNC people may proceed through a social transition (e.g., changes in gender expression, gender role, name, pronoun, and gender marker) and/or a medical transition (e.g., hormone therapy, surgery, and/or other interventions).

Transsexual: term to describe TGNC people who have changed or are changing their bodies through medical interventions (e.g., hormones, surgery) to better align their bodies with a gender identity that is different than their sex assigned at birth. Not all people who identify as transsexual consider themselves to be TGNC. For example, some transsexual individuals identify as female or male, without identifying as TGNC. Transsexualism is used as a medical diagnosis in the [World Health Organization’s \(2015\)](#) International Classification of Diseases version 10.

Two-spirit: term used by some Native American cultures to describe people who identify with both male and female gender roles; this can include both gender identity and sexual orientation. Two-spirit people are often respected and carry unique spiritual roles for their community.

Appendix B

Guidelines for Psychological Practice With Transgender and Gender Nonconforming People

Foundational Knowledge and Awareness

Guideline 1. Psychologists understand that gender is a nonbinary construct that allows for a range of gender identities and that a person’s gender identity may not align with sex assigned at birth.

Guideline 2. Psychologists understand that gender identity and sexual orientation are distinct but interrelated constructs.

Guideline 3. Psychologists seek to understand how gender identity intersects with the other cultural identities of TGNC people.

Guideline 4. Psychologists are aware of how their attitudes about and knowledge of gender identity and gen-

der expression may affect the quality of care they provide to TGNC people and their families.

Stigma, Discrimination, and Barriers to Care

Guideline 5. Psychologists recognize how stigma, prejudice, discrimination, and violence affect the health and well-being of TGNC people.

Guideline 6. Psychologists strive to recognize the influence of institutional barriers on the lives of TGNC people and to assist in developing TGNC-affirmative environments.

Guideline 7. Psychologists understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people.

(Appendices continue)

Life Span Development

Guideline 8. Psychologists working with gender-questioning and TGNC youth understand the different developmental needs of children and adolescents and that not all youth will persist in a TGNC identity into adulthood.

Guideline 9. Psychologists strive to understand both the particular challenges that TGNC elders experience and the resilience they can develop.

Assessment, Therapy, and Intervention

Guideline 10. Psychologists strive to understand how mental health concerns may or may not be related to a TGNC person's gender identity and the psychological effects of minority stress.

Guideline 11. Psychologists recognize that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care.

Guideline 12. Psychologists strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people.

Guideline 13. Psychologists seek to understand how parenting and family formation among TGNC people take a variety of forms.

Guideline 14. Psychologists recognize the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers.

Research, Education, and Training

Guideline 15. Psychologists respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.

Guideline 16. Psychologists Seek to Prepare Trainees in Psychology to Work Competently With TGNC People.

Suggested citation:

American Psychological Association. (2015). Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. *American Psychologist*, 70 (9), 832-864. doi: 10.1037/a0039906

DOC. 69-26

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

REV. PAUL A. EKNES-TUCKER,)	
<i>et al.</i> ,)	
)	
<i>Plaintiffs</i> ,)	
)	
v.)	No. 2:22-cv-00184-LCB-SRW
)	
KAY IVEY, in her official capacity)	
as Governor of the State of Alabama,)	
<i>et al.</i> ,)	
)	
<i>Defendants.</i>)	

DECLARATION OF CORINNA COHN

My name is Corinna Cohn. I am over the age of 19, I am qualified to give this declaration, and, I have personal knowledge of the matters set forth herein.

In or about 2nd grade, I saw a psychologist for problems related to being bullied and emotional regulation. After less than a year, my parents chose to discontinue therapy. I continued to be bullied and had problems forming friendships. Other boys excluded me from social activities. Later in elementary school I began to pray to be made into a girl, which I thought would allow me to fit in better. This became a fixation for me.

In high school, I confessed to my parents that I wanted to become a woman. They brought me to see the same psychologist I'd had as a child, and she diagnosed me with having gender identity disorder. Upon receiving this diagnosis, my parents again chose to discontinue my therapy. I continued to have problems socializing at school and experienced depression and anxiety on a daily basis.

At the age of 17, I gained access to the Internet. This was prior to the popularization of the World Wide Web, but I was able to use message boards and chat in order to find other members of what today would be called the “trans community”. Adult transgender women befriended me, supplied me with validation and support, and provided information on how I could transition to also become a transgender woman.

At the age of 18, I resumed my sessions with my psychologist with the goal of receiving a prescription for cross-sex hormones and eventual sex reassignment surgery. Due to my prior relationship with my psychologist, I was able to gain a letter of recommendation to an endocrinologist and was prescribed estrogen. The endocrinologist was referred to me by transgender friends on the Internet. I began living as a woman and had my legal identification updated to reflect my chosen name.

I had sex reassignment surgery in Neenah, Wisconsin in 1994. I was only 19 years old. Securing the appointment required letters from two therapists along with a letter from my endocrinologist. My surgeon told me I was the second-youngest patient he had operated on. The surgery involved removal of my testicles, penectomy, and vaginoplasty. It was successful and without complication.

After healing from my sex change surgery I thought that my transition journey was over. I discontinued therapy, and I began focusing on my career. I found it was easier to socialize and make new friends with my new confidence and feelings of being my authentic self. As I reached my late twenties, my friends began pairing off and starting families. I discovered that it was very difficult to find a partner who wanted to do the same with me.

Although I was in denial for several years, I eventually realized that my depression and anxiety related to my gender identity had not resolved. It was not unusual for me to spend entire weekends in my room crying and entertaining thoughts of suicide.

In my mid-thirties I became interested in radical feminism. I am not a feminist, nor have I ever been, but I wanted to reconcile how feminist concepts applied to people like myself: males who try to turn ourselves into women. One of the concepts I found pivotal was the feminist criticism of biological essentialism, which challenges the idea that men and women are destined to fulfill rigid sex roles. Once I understood this criticism I realized that my more stereotypically feminine attitudes and behaviors did not therefore make me a woman, but rather a feminine man. In retrospect, my self-perception of being a woman also required that I overlook or discount traits that are more stereotypically masculine. Although it took time for this realization to fully sink in, a side effect was that I stopped having bouts of depression and anxiety related to my gender identity. I have not had any depressive episodes related to gender identity in ten years. As a teenager I was unprepared to understand the consequences of my decision to medicalize my transition despite the rigorous controls that were then in place to ensure that patients would not be harmed from gender affirming care.

In 2019, I co-founded a non-profit dedicated to advocating for patients of gender care services. Through the Gender Care Consumer Advocacy Network (GCCAN), I have spoken with other patients and gender clinicians to identify opportunities that can benefit patients and improve the quality of care delivered. The gender clinicians I have spoken with have admitted that they do not follow the World Professional Association of Transgender Health standards of care because they are viewed to be needlessly restrictive. It is GCCAN's position to oppose

criminalization of gender affirmative care, but it is evident that gender clinicians treating adolescents are not abiding by the existing standards of care and that they are not self-regulating. Individuals are in a difficult position to be made whole when injured as it is common for transgender patients to rationalize or forgive poor treatment lest they lose access to their providers altogether. The reticence of gender clinicians to avoid harming their patients has created a vacuum for legislators to address.

I wish I could persuade other boys who wish to become women that the changes they seek are only superficial. Hormones and surgery are unable to reveal an authentic self, and anyone who promises otherwise is, in my opinion, deliberately misleading young people to follow a one-way track to a lifetime of medicalization. Although some people may choose to transition, and may even enjoy a higher quality of life, there is no reason why this irreversible decision needs to be made in adolescence. Adults who advocate for adolescent transition do so without understanding what tradeoffs early transition entails, which includes the loss of fertility, the likelihood of sexual dysfunction, and the likelihood of surgical complication inflicted at an early age from elective procedures. Unfortunately, I do understand some of these tradeoffs. While I would not want to see well-meaning family doctors prosecuted for trying to help a dysphoric child, until such a time as there is clear evidence that adolescent transition is likely to help, adolescent gender affirming care should be heavily scrutinized.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed on April 26, 2022.


Corinna Cohn

DOC. 69-27

**UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

REV. PAUL A. EKNES-TUCKER;)
BRIANNA BOE, individually and on)
behalf of her minor son, MICHAEL)
BOE; JAMES ZOE, individually and)
on behalf of his minor son,)
ZACHARY ZOE; MEGAN POE,)
individually and on behalf of her)
minor daughter, ALLISON POE;)
KATHY NOE, individually and on)
behalf of her minor son,)
CHRISTOPHER NOE; JANE MOE,)
Ph.D; and RACHEL KOE, M.D.)

Plaintiffs,)

v.)

KAY IVEY, in her official capacity)
As Governor of the State of Alabama;)
STEVE MARSHALL, in his official)
capacity as Attorney General of the)
State of Alabama; DARYL D.)
BAILEY, in his official capacity as)
District Attorney for Montgomery)
County; C. WILSON BAYLOCK, in)
his official capacity as District)
Attorney for Cullman County;)
JESSICA VENTIERE, in her official)
capacity as District Attorney for Lee)
County; TOM ANDERSON in his)
official capacity as District Attorney)
for the 12th Judicial Circuit; and)
DANNY CARR, in his official)
Capacity as District Attorney for)
Jefferson County.)

Defendants)

CIVIL ACTION #
2:22-cv-00184-LCB-SRW

**Declaration of Sydney Wright
In Support of Defendants'
Opposition to Plaintiffs'
Motion for Preliminary Injunction**

I, Sydney Wright, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction.

2. Alabama's Vulnerable Child Compassion and Protection Act ("VCCAP") is a necessary, potentially life-saving law that will protect vulnerable children and their parents from the heartbreaking regret, irreversible physical changes, and emotional pain that I have experienced after undertaking medical interventions aimed at "transitioning" me from a female to a male.

3. I'm a 23-year-old woman who spent a year as a "transman" after being rushed into taking mega doses of testosterone at age 18.

4. I began to identify as transgender in 2017 during counseling after reading about transgenderism on the internet. I had not experienced feelings of gender dysphoria prior to this time.

5. A neighborhood boy engaged in sexually touching with me from age 5 to 12. This awakened sexual feelings at too young an age and caused me to feel unsafe.

6. I was very tomboyish growing up and was sometimes bullied. I began having same-sex attractions as a teen. I was raised in a strict religious home, where homosexuality was frowned upon. When my father learned that I had same-sex attractions he kicked me out of his house (my parents divorced when I was 12) and I went to live with my mother.

7. I was first introduced to transgenderism on social media at around age 18. I began to question if I was really a man because I was attracted to girls.

8. I cut my long blond hair, which caused me to look more masculine. This made me want to move quickly through transition.

9. I started seeing a counselor on June 13, 2017. I disclosed to the counselor that I had been sexually molested for years as a child, about my parents' contentious divorce, and about my dysfunctional relationship with both parents. I also disclosed that I was in a dysfunctional marriage to a physically abusive woman who brought and sold drugs.

10. The counselor did not explore how any of this history might be contributing to my dysphoria, but simply asked some questions and diagnosed me with gender dysphoria and gave me a recommendation to a physician for testosterone treatment within five weeks of our first meeting.

11. My frame of mind at the time, at age 18, was that I believed I might have been "born in the wrong body" and needed to correct it. But I was also unsure,

confused, and in need of guidance. Had a professional told me the truth and helped me explore why I was distressed by being a girl (and a lesbian) in a nonjudgmental way, I would not have proceeded with testosterone.

12. However, that was not the case, and I met with the doctor to whom the counselor referred me. The visit lasted less than 10 minutes, during which time the doctor was curt and rude. He asked me for my “hormone letter,” but did not open it or read it. He did not ask any questions to confirm that I had gender dysphoria or any questions concerning my medical history or past or present physical condition or symptoms.

13. I told the doctor that I was nervous, and he curtly asked, “Do you want to do this?” and told me I could pick up the testosterone that day. I asked the doctor if he would administer the injections in the office. He said no and told me to go home and look on You Tube to find out how to give myself the shots, indicating “There’s no wrong way to do it. I later learned that the shots were supposed to be administered intramuscularly after administering them subcutaneously in my stomach which caused pain and bubbles to form under the skin.

14. My voice began to deepen, which I have found out is going to be a permanent, irreversible change.

15. I gained over 50 pounds and became pre-diabetic. When I mentioned this to the physician during a follow up appointment he just told me to start working out.

16. After about a year on testosterone, test results revealed that my blood was starting to thicken, my red blood cell count was too high, and I was developing a blood disorder that could lead to a heart attack or stroke if not controlled. I did some research and believe this was polycythemia. I began experiencing chest pains and was told I had developed tachycardia.

17. I began suffering excruciating and constant abdominal pain and could not eat. Testing did not reveal any disorders. I was later diagnosed with irritable bowel syndrome, which I continue to suffer with.

18. The pain was becoming so excruciating that I became suicidal. My mental health was deteriorating as I was suffering from depression, irritability, insecurity, and exhaustion.

19. The changes brought on by the testosterone caused my family tremendous emotional distress. Finally, my grandfather sat me down with tears in his eyes and asked me to stop what I was doing to myself. That was a saving grace. I would have let the treatment kill me before admitting that I had made a mistake. My grandfather's intervention saved my life.

20. I stopped taking testosterone and resumed living as a female. My physical and mental health have improved, but I continue to suffer adverse effects from the treatments, including a deepened voice and digestive issues that I've been told will be permanent.

21. I also suffer extreme regret for the choices I made as a teenager. I trusted the doctors' advice. They were the experts, who was I as a confused and scared 18 year old not to listen to them?

22. But telling an 18-year-old girl that mega-doses of testosterone would fix her mental health problems? They didn't even talk to me about other treatment options! No doctor or therapist suggested I give myself time to grow up, or suggested counseling for what was causing my feelings – no doctor or therapist told me most young people outgrow their feelings of wanting to be the opposite sex. The only advice I got was to take mega-doses of testosterone.

23. Unfortunately, there are more and more young people like me being deceived every day, being told that the solution to their insecurity and identity problems is to get a "sex change." The problem is, a person's sex can't really be changed. You can take hormones and have cosmetic surgeries, but that doesn't really change your sex, or solve your problems. I wish I knew that when I was younger.

24. The VCCAP Act is a critical and necessary law that will help spare my fellow Alabama citizens from being similarly misled and suffering the distress I am

continuing to suffer because of the availability of medical interventions to minors under age 19. This law will save lives.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: April 04/29/2022

Sydney Wright

Sydney Wright

Signature: Sydney E Wright
Sydney E Wright (Apr 29, 2022 18:57 EDT)

Email: [REDACTED]

DOC. 69-28

**UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

REV. PAUL A. EKNES-TUCKER;)
BRIANNA BOE, individually and on)
behalf of her minor son, MICHAEL)
BOE; JAMES ZOE, individually and)
on behalf of his minor son,)
ZACHARY ZOE; MEGAN POE,)
individually and on behalf of her)
minor daughter, ALLISON POE;)
KATHY NOE, individually and on)
behalf of her minor son,)
CHRISTOPHER NOE; JANE MOE,)
Ph.D; and RACHEL KOE, M.D.)

Plaintiffs,)

v.)

KAY IVEY, in her official capacity)
As Governor of the State of Alabama;)
STEVE MARSHALL, in his official)
capacity as Attorney General of the)
State of Alabama; DARYL D.)
BAILEY, in his official capacity as)
District Attorney for Montgomery)
County; C. WILSON BAYLOCK, in)
his official capacity as District)
Attorney for Cullman County;)
JESSICA VENTIERE, in her official)
capacity as District Attorney for Lee)
County; TOM ANDERSON in his)
official capacity as District Attorney)
for the 12th Judicial Circuit; and)
DANNY CARR, in his official)
Capacity as District Attorney for)
Jefferson County.)

Defendants)

CIVIL ACTION #
2:22-cv-00184-LCB-SRW

**Declaration of Carol Frietas
In Support of Defendants'
Opposition to Plaintiffs'
Motion for Preliminary Injunction**

I, Carol Frietas, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction.

2. Alabama's Vulnerable Child Compassion and Protection Act ("VCCAP") is a necessary, potentially life-saving law that will protect vulnerable children and their parents from the heartbreaking regret, irreversible physical changes, and emotional pain that I have experienced after undertaking medical and surgical interventions aimed at "transitioning" me from a female to a "male."

3. As a youth, I was what today is called "gender non-conforming," but I lived in a household where gender expression was strictly aligned with cultural stereotypes. I was not allowed to wear boys' clothes or play boys' sports.

4. At puberty I realized I was same-sex attracted with crushes on girls. I became depressed and anxiety-ridden as I feared what "being gay" might mean to how I lived my life and my family relationships. I dropped out of school.

5. At age 20, I began to meet other LGBT youth and my life stabilized. However, I also learned that many masculine females, like me, felt that they were "born in the wrong body" and were transitioning, so I adopted that persona.

6. I went to a gender therapist who diagnosed me with gender dysphoria and told me that transition was the only treatment that would alleviate my discomfort and anxiety.

7. However, at that time there were gatekeeping standards for gender transition, which required that I first live as man for six months, including using a male name, showing a male appearance, and using male spaces. I had very large breasts and could not pass for a male in male spaces, so I did not pursue testosterone at that time. I viewed myself as a male trapped in the “wrong body,” but my mental health otherwise was stable.

8. In 2014, I revisited the idea of transitioning, believing it would make me feel better because I was undergoing trauma in various forms. My grandmother who had practically raised me died. I had suffered severe abuse and neglect in childhood, and in retrospect believe I was experiencing symptoms of PTSD from that. I had just become a new mother a couple of months before my brother-in-law committed suicide.

9. I spiraled downward and wanted out. I couldn’t commit suicide because I was a mother, so I returned to the idea of transition, believing it would help me feel better. By that time the requirements for testosterone had lessened. I went to Planned Parenthood for testosterone and was given it right away, with no information. I was not given any information on uterine atrophy, vaginal atrophy,

or other effects of testosterone and the staff did not talk about any of my emotional or mental health issues.

10. Four months after starting testosterone, I went to a plastic surgeon for a mastectomy. I needed a letter from a therapist and received one from the therapist who had affirmed me and originally recommended transition. As was true with testosterone, I was not given any information about the procedure. Instead I had a consultation with the surgeon, who said “this is what we are going to do,” drew on my chest, took pictures and asked me what I wanted out of the surgery. He said “we’ll create a masculine looking chest, you’ll look great.”

11. During the first four months on testosterone menstruation stopped, my sex drive went way up, my voice deepened, and facial and body hair came in. As I continued on testosterone, my personality changed drastically and my verbal abilities declined. Testosterone lowered and muted my emotions and empathy, but also gave me a lot of energy and a sense of a high. My depression and anxiety worsened to the point that I was having such severe panic attacks that I could not leave home. I told my doctors that I thought the testosterone was making the anxiety worse, but they said no.

12. I went to a psychiatrist to specifically to deal with the depression and I was provided with an anti-depressant that really worked. I felt mentally stable and able to address the trauma that led me to transition.

13. Within a month of starting the anti-depressant, I realized that I had not needed to transition. It was the biggest mistake I had ever made. I did not detransition for a year because I couldn't believe that it was so easy, *i.e.*, that anti-depressants alleviated my depression and enabled me to think clearly and reason better. This allowed me address my internalized homophobia and childhood abuse through therapeutic means.

14. Meanwhile, my health began going downhill. Before going on testosterone, I had no health problems. After being on it for four years, I was pre-diabetic, had high cholesterol, and had a high red blood cell count to the point that doctors were recommending that I donate blood to reduce the volume.

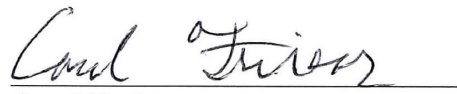
15. I stopped taking testosterone and four months later my blood work was back down to normal. I thought to myself "How do they [doctors] not know about this?" Going off testosterone allowed me to finally sleep. I felt like I never slept all the time that I was taking testosterone. Going off testosterone also helped with empathy and other emotions. My personal relationships, including my relationship with my wife, were better.

16. I believe that healthcare providers did not ask me about mental health issues because they believed that those issues were caused by gender dysphoria and that transitioning would fix the problem. In fact, the opposite was true.

17. I would have been spared physical, psychological, and emotional losses if I had received a proper diagnosis and treatment for PTSD and depression before undergoing years of medical and surgical interventions. Alabama's VCCAP Act is necessary and essential because it will give children and adolescents the chance to work through and address their underlying issues such as depression or PTSD effectively without being pulled onto the affirmation conveyor belt. Hormones and surgery are irreversible decisions that children and adolescents are incapable of making.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: April 29, 2022.


Carol Freitas

DOC. 69-29

**UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

REV. PAUL A. EKNES-TUCKER;)
BRIANNA BOE, individually and on)
behalf of her minor son, MICHAEL)
BOE; JAMES ZOE, individually and)
on behalf of his minor son,)
ZACHARY ZOE; MEGAN POE,)
individually and on behalf of her)
minor daughter, ALLISON POE;)
KATHY NOE, individually and on)
behalf of her minor son,)
CHRISTOPHER NOE; JANE MOE,)
Ph.D; and RACHEL KOE, M.D.)

Plaintiffs,)

v.)

KAY IVEY, in her official capacity)
As Governor of the State of Alabama;)
STEVE MARSHALL, in his official)
capacity as Attorney General of the)
State of Alabama; DARYL D.)
BAILEY, in his official capacity as)
District Attorney for Montgomery)
County; C. WILSON BAYLOCK, in)
his official capacity as District)
Attorney for Cullman County;)
JESSICA VENTIERE, in her official)
capacity as District Attorney for Lee)
County; TOM ANDERSON in his)
official capacity as District Attorney)
for the 12th Judicial Circuit; and)
DANNY CARR, in his official)
Capacity as District Attorney for)
Jefferson County.)

Defendants)

CIVIL ACTION #
2:22-cv-00184-LCB-SRW

**Declaration of Barbara F.*
In Support of Defendants'
Opposition to Plaintiffs'
Motion for Preliminary Injunction**

I, Barbara F.¹ declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction.

2. Alabama's Vulnerable Child Compassion and Protection Act ("VCCAP") provides parents necessary protections against manipulation and coercion on the part of health care providers, ex-spouses and confused children to comply with demands for medical and surgical interventions aimed at "affirming" a child's professed discordant gender identity under threats of alienation or loss of a child to suicide.

3. Because there is no such parent and child-protective law in place in my home state, I have been subjected to alienation from my daughter, coercion, manipulation, and blatant disregard for my parental right to make medical and mental health decisions for my child. The VCCAP will prevent parents and children in Alabama from suffering similar harms. It will actually restore the rights of all parents, not just those who agree with demands for "gender-affirming" medical

¹ Declarant is submitting this Declaration using a pseudonym to protect the privacy of her children and other family members.

interventions, to make medical and mental health care decisions for their children that are truly in the best interest of their child's healthy development.

4. When my daughter, B., was 11 years old she said she identified as a boy and wanted to be referred to by an alternate male name. This occurred after she had endured ridicule from her father (my ex-husband) for laughing like me and witnessed her brother getting preferential treatment from her father.

5. B's father championed her new 'male' identity and began harassing me for not affirming it. He accused me of emotional abuse and called child protection services against me. B's father convinced B. to not participate in visitations with me unless I affirmed the discordant identity.

6. Shortly after B announced that she identified as a boy, I acted on the advice of our family physician and took B to a gender clinic. I naively believed that I would have an opportunity to seek a psychological evaluation and psychological counseling for B. and discuss her sudden identification as a boy prior to any interventions aimed at "affirming" her choice.

7. However, when my daughter and I arrived at the clinic the staff psychologist did an evaluation, but said that she did not have time to see B. regularly to give more in depth psychological help. I stated that believed that B. needed to have psychological counseling before any medical interventions were begun.

8. I told the clinic staff that I did not consent to further consultations regarding medical intervention. I had done some research on the puberty blockers and hormone therapy being suggested for my daughter and was concerned about their unproven safety and efficacy.

9. The clinic staff ignored my directions and, without telling me, an endocrinologist met with my 12-year-old daughter privately and with her father to discuss beginning puberty blockers. The endocrinologist then came in to meet with my daughter and me. When I raised concerns about the puberty blockers, the endocrinologist said that there are “no studies that show the drugs aren’t safe.” She also told me *in front of* my daughter that I needed “to get on board [with providing puberty blockers and hormones] if I don’t want my daughter to commit suicide.”

10. I have repeatedly notified clinic staff orally and in writing that I do not consent to their treating my daughter. My ex-husband and I have shared decision-making authority for our children’s medical care, so no care is supposed to be provided unless both of us consent. Nevertheless, the clinic and B.’s father have continued with regular consultations with my daughter without my consent.

11. I have reviewed documents from the clinic in which staff say that they plan to “convince me” to consent to the medical interventions, completely disregarding my legal rights and role as B’s mother.

12. The availability and promotion of “gender affirming” medical interventions for minors such as my daughter has been used to drive a wedge between B. and me, to prevent B. from receiving counseling for underlying mental health issues and to expose her to unknown long-term medical and mental health consequences without my consent. The notion of “informed consent” or parental decision-making is non-existent.

13. The VCCAP Act prevents such coercive manipulation and potential harm against Alabama’s vulnerable children and should be upheld for the protection of children and their families.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: April 28, 2022.

/s/ Barbara F.
Barbara F. (pseudonym)
[original signature available on request]

DOC. 69-30



**UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

REV. PAUL A. EKNES-TUCKER;)
BRIANNA BOE, individually and on)
behalf of her minor son, MICHAEL)
BOE; JAMES ZOE, individually and)
on behalf of his minor son,)
ZACHARY ZOE; MEGAN POE,)
individually and on behalf of her)
minor daughter, ALLISON POE;)
KATHY NOE, individually and on)
behalf of her minor son,)
CHRISTOPHER NOE; JANE MOE,)
Ph.D; and RACHEL KOE, M.D.)

Plaintiffs,)

v.)

KAY IVEY, in her official capacity)
As Governor of the State of Alabama;)
STEVE MARSHALL, in his official)
capacity as Attorney General of the)
State of Alabama; DARYL D.)
BAILEY, in his official capacity as)
District Attorney for Montgomery)
County; C. WILSON BAYLOCK, in)
his official capacity as District)
Attorney for Cullman County;)
JESSICA VENTIERE, in her official)
capacity as District Attorney for Lee)
County; TOM ANDERSON in his)
official capacity as District Attorney)
for the 12th Judicial Circuit; and)
DANNY CARR, in his official)
Capacity as District Attorney for)
Jefferson County.)

Defendants)

_____)

CIVIL ACTION #
2:22-cv-00184-LCB-SRW

**Declaration of John Doe*
In Support of Defendants'
Opposition to Plaintiffs'
Motion for Preliminary Injunction**

I, John Doe¹, declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am submitting this Declaration in support of Defendants' opposition to Plaintiffs' Motion for a Temporary Restraining Order and Preliminary Injunction.

2. I am the father of two sons including a 17-year-old, C. (a pseudonym), who is being seen by Dr. Stephen Rosenthal and his team at UCSF, who is an expert witness who has been retained by the Plaintiffs in this case.

3. I have read Dr. Rosenthal's Declaration. I can testify that his statements regarding the standard of care for transgender children, and particularly his claims that parents have the opportunity to exercise informed consent regarding medical interventions for their child are not true with regard to my son.

4. Dr. Rosenthal claims that medical treatment is done in consultation with the patient's family. In my case this is not true. Dr. Rosenthal's institution has actively worked to prevent my participation in my son's care to the point of providing information to the attorney representing my son in family court aimed at

¹ Declarant is submitting this Declaration using a pseudonym for himself and his son to protect the privacy of his child and family.

stripping me of custody because I would not affirm my son in a discordant gender identity.

5. In fact, I knew nothing about my son receiving life-altering medical interventions until I received a statement from my insurance carrier showing that it had paid more than \$209,000 to a child and adolescent gender clinic at UCSF. Even then, I did not know what the payment was for until I asked my ex-wife. She emailed me that she was “pleased” to report that our son had been given an implant of Supprelin (used to suppress testosterone) and was receiving estradiol (estrogen) pills.

6. My research on these substances showed that they chemically castrate patients and are even used specifically for that purpose in some cases for sex offenders. Yet here my 17-year-old son was receiving these drugs from Dr. Rosenthal ostensibly to improve his health and well-being.

7. I have learned that Supprelin is Dr. Rosenthal’s preferred method for administering puberty blockers for adolescents like my son. Supprelin requires surgical implantation, meaning that it is a surgical intervention administered to children under the age of 18, which is contrary to Dr. Rosenthal’s testimony that surgical interventions are not prescribed for minors and not recommended by the “Standards of Care.”

8. I contend that Dr. Rosenthal's surgical implantation of Supprelin into my son also violates the family court's custody order, which UCSF has a copy of, which states that my son is not permitted to "undergo any gender identity related surgery" until he is 18 absent a written agreement of **both parents** or order of the court. I did not agree to the surgical implantation, nor is there any court order permitting it, yet C.'s records show a surgical procedure performed on him to insert the Supprelin. This further calls into question Dr. Rosenthal's testimony regarding the "standards of care" employed in "gender-affirming" interventions.

9. Dr. Rosenthal's testimony also contradicts his actions with my son in that after UCSF surgically implanted my 17 year old son with Supprelin LA (without my knowledge or consent but paid for by my health insurance), Dr. Rosenthal discussed follow-up surgical options with him without both parents present. Dr. Rosenthal discussed breast implants, facial feminization and bottom surgery with my son at age 17 years and 5 months.

10. Rosenthal claims to "provide the patient and their family the information they need to make an informed decision about whether to proceed with the treatment." Again, that is not true regarding the treatment prescribed for my son. When I sought information about alternatives, such as "watchful waiting," and whether patients are assessed by Ray Blanchard's typology of transsexuals, instead

of receiving an answer I was subjected to actions in the family court aimed at stripping me of custody because of my questioning of the protocols at UCSF.

11. Similarly, when I provided Dr. Rosenthal with research that I had found which suggests that puberty blockers can cause cognitive harm and asked questions I received no response, contrary to his testimony that parents are involved to ensure everyone involved has the information they need to make an informed decision.

12. Further contradicting his claim of “informed” decision-making is seen in the form presented to and discussed with my then 16 year old son. The form did not indicate that permanent and irreversible sterility is a potential and likely outcome of the recommended treatment, particularly when puberty blockers are combined with estrogen as is the case with C.

13. Dr. Rosenthal’s actions with regard to the treatment of my son differ significantly from the “safe and effective” protocols that he claims are part of “gender-affirming” treatments. His refusal to respond to my questions as the concerned father of his patient belie his testimony about the information-rich and collaborative environment he claims is part of the “gender-affirming” care he provides.

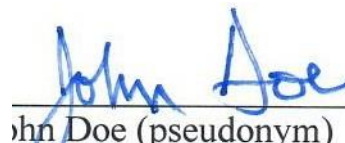
14. My experiences with Dr. Rosenthal instead point to an ideologically driven conveyor belt onto which vulnerable children like my son are placed and processed without the safeguards usually inherent in medical procedures.

15. Parental participation is tolerated only so long as it is affirming of the ideology. If, as in my case, the parent asks questions instead of immediately affirming the agenda, then that parent is disregarded even to the point, as in my case, of having their rights stripped away.

16. The availability of "gender-affirming" medical interventions for vulnerable children experiencing distress about changes in their bodies enables the ideological conveyor belt to proceed unhindered, leaving in its wake sterilized, drug-dependent and dysfunctional young adults, shattered relationships, and distrust in the medical profession.

17. Alabama's efforts to ban these treatments for minors in the VCCAP is necessary to prevent the irreversible and incalculable harms caused by the unchecked gender medicine machine. The VCCAP law will save Alabama families from similar devastation.

Dated: April 28, 2022.


John Doe (pseudonym)

DOC. 69-31

**UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION**

REV. PAUL A. EKNES-TUCKER;)
BRIANNA BOE, individually and on)
behalf of her minor son, MICHAEL)
BOE; JAMES ZOE, individually and)
on behalf of his minor son,)
ZACHARY ZOE; MEGAN POE,)
individually and on behalf of her)
minor daughter, ALLISON POE;)
KATHY NOE, individually and on)
behalf of her minor son,)
CHRISTOPHER NOE; JANE MOE,)
Ph.D; and RACHEL KOE, M.D.)

Plaintiffs,)

v.)

KAY IVEY, in her official capacity)
As Governor of the State of Alabama;)
STEVE MARSHALL, in his official)
capacity as Attorney General of the)
State of Alabama; DARYL D.)
BAILEY, in his official capacity as)
District Attorney for Montgomery)
County; C. WILSON BAYLOCK, in)
his official capacity as District)
Attorney for Cullman County;)
JESSICA VENTIERE, in her official)
capacity as District Attorney for Lee)
County; TOM ANDERSON in his)
official capacity as District Attorney)
for the 12th Judicial Circuit; and)
DANNY CARR, in his official)
Capacity as District Attorney for)
Jefferson County.)

Defendants)

CIVIL ACTION #
2:22-cv-00184-LCB-SRW

**Declaration of John Roe*
In Support of Defendants'
Opposition to Plaintiffs'
Motion for Preliminary Injunction**

I, John Roe¹ declare as follows:

1. I am over the age of 18 years and am not a party to this action. I have actual knowledge of the following facts and if called upon to testify to them could and would do so competently. I am a resident of Alabama and the father of a son who said he was gender dysphoric and who was socially transitioned at school without our knowledge and referred for “gender transition” medical treatments. I am submitting this Declaration in support of Defendants’ opposition to Plaintiffs’ Motion for a Temporary Restraining Order and Preliminary Injunction.

2. Alabama’s Vulnerable Child Compassion and Protection Act (“VCCAP”) will protect vulnerable children and provide parents necessary protections against manipulation and coercion on the part of health care providers and confused children to comply with demands for medical and surgical interventions aimed at “affirming” a child’s professed discordant gender identity under threats of alienation or loss of a child to suicide.

3. The VCCAP will provide parents with the information necessary to exercise their rights to make mental health and medical care decisions for their children without the secrecy and interference from the government, particularly

¹ Declarant is submitting this Declaration using a pseudonym to protect the privacy of his child and other family members.

public school and coercive influence of mental health professionals, that I experienced.

4. My son, J., has been diagnosed with ADHD and anxiety. He never expressed any distress about his sex until middle school, his eighth grade year. During that time, J. spent a lot of time online and was interested in anime and role-playing games. He also became friends with a girl who identified as trans, which piqued his curiosity.

5. Between eighth and ninth grade, J. left a note for his mother stating that that he was “transgender.” He signed the note “your daughter.” My wife did not tell me about the note at that time. She spoke with J. who said he “felt more female than male.”

6. J. later left me a similar note saying that he had gender dysphoria as long as he can remember.

7. During a therapy session J. said he started feeling that he was transgender in the 8th grade, but then “did his research” through online searches and confirmed his conclusion. I learned that he had watched internet trans influencers, viewed YouTube videos, and answered online questionnaires to self-diagnose gender dysphoria in eighth grade.

8. I learned after the fact that J.’s public school had facilitated J. socially transitioning to a female gender identity without the knowledge or consent or my

wife or me. Without informing us, the school went along with J.'s wishes to be called by a female name and pronouns in ninth grade. We also later learned that J. was wearing a skirt at school without our knowledge. I found out about the new female name being used by the school as if by accident through communication with a teacher and learned that J. was using female pronouns at school through an art project.

9. We took J. to a therapist who did not do a psychological evaluation, but diagnosed him with OCD, anxiety, and depression as well as the previously diagnosed ADHD.

10. During a family therapy session, the therapist ignored J.'s other co-morbidities and focused solely on gender dysphoria. The therapist called J. "courageous." The therapist printed out a handout from an advocacy group. She was trying to bring my wife and I on board with letting our child lead with diagnosis and treatment.

11. The therapist said that kids have a sense of their identity by age 3 or 4, but provided no scientific support.

12. *With J. present*, the therapist told me and my wife that kids are more likely to attempt suicide and run away from home if they are not affirmed in their chosen identity.

13. After the third or fourth visit the therapist recommended that we take J. to Magic City gender clinic to receive puberty blockers or cross-sex hormones.

14. We did not follow up on that recommendation. I researched the clinic and the proposed interventions and was concerned about what the interventions would steer my son toward. I believed that for a child of J.'s age struggling as he was with self-esteem, amplified by his other co-morbidities, these medical interventions were not going to solve his real underlying issues long-term. I believed that the interventions were permanent changes with life-long consequences to a child's body for a problem of the mind that could be solved by a less invasive route.

15. I believed my son needed to understand that his body was not the problem, but that his thoughts were and that they could be assisted to bring him more peace with his body through therapy.

16. A total ban on these treatments for children, such as provided in the VCCAP Act is necessary because the medical gatekeepers are not doing their job. They are not following proper professional protocols, are not safeguarding confused adolescents, and not self-regulating. They are allowing adolescents, who are prone to making rash decisions, to self-harm and harm their future. They are also pressuring parents with talk of suicide in front of the adolescent. These treatments have unknown long-term effects and are experimenting on children.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: April 28, 2022.

A handwritten signature in green ink that reads "John Roe". The signature is written in a cursive style and is positioned above a horizontal line.

John Roe (pseudonym)